

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 41c & 2c filed 11/20/67

15499

CERTIFICATE OF DEATH

15497

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY H.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 61 1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d. STREET ADDRESS 18 Severndale Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gloria Middle Blanche Last Elizabeth Type or print Adams				4. DATE OF DEATH Month November Day 18 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 March 1924		9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George C. McAvoy				14. MOTHER'S MAIDEN NAME Mary Lamb			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 15, 1967 , to Nov. 18, 1967 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Nov. 18, 1967 , and that death occurred at 6:45 M. , from causes and on the date stated above.							
22a. SIGNATURE James J. Nordlund, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> F.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Nov. 19, 1967			
22c. PHYSICIAN'S NAME (Type) James J. Nordlund, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/22/67	23c. NAME OF CEMETERY OR CREMATORY Seaside Cem.		23d. LOCATION (City or Town) (County) (State) Palermo, N.J.			
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR NOV 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1944

1944

THE UNITED STATES OF AMERICA

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE
TO THE SECRETARY OF THE INTERIOR
FOR THE YEAR 1944

FOR STATE
HEALTH DEPT.

15500

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15488

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>4013 1/2 PLYERS MILL RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MELVIN</u> First Middle Last		4. DATE OF DEATH <u>NOV 19 1967</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/97</u>
9. AGE (In years lost birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT ADDISON</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>NIECE</u> Address <u>Kensington, MD.</u>		18. <u>GLORIA HOPKINS - 4007 PLYERS MILL RD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, tuberculous</u> DUE TO (b) <u>Exacerbation of a chronic pulmonary tuberculosis</u> DUE TO (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John L. Ball</u> M.D.		22. DATE SIGNED <u>Nov-19-1967</u>	
EXAMINER'S NAME (Type) <u>Robert L. Snowden</u>		Address (Street, city, town, or county) <u>Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 24 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>MT. ZION, MONTG. MD.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. J...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15489

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 1201 Forest Glen Road	
3. NAME OF DECEASED (Type or print) Harry First NMN Middle Ager Last		4. DATE OF DEATH Month November Day 12 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1919
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
11. BIRTHPLACE (State or foreign country) Detroit, Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Ager		14. MOTHER'S MAIDEN NAME Kate	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 579-07-8485	
17. INFORMANT Sam Cohen		Address 4201 Cathedral Ave. N.W. Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO (b) Acute Coronary Insufficiency DUE TO (c) Coronary Artery Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Underdetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 13, 1967	
23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR B Baugant & Son		25a. REC'D BY REGISTRAR NOV 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED Nov. 12, 1967	

102221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>2 years</u>				d. STREET ADDRESS <u>2528 B Holman Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2528 B Holman Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Caroline</u> Middle <u>Mae</u> Last <u>Albright</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 18, 1890</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>20</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ALTOONA Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel HOFFMAN</u>				14. MOTHER'S MAIDEN NAME <u>Sara DEVER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>170-38-5631</u>		17. INFORMANT <u>Margaret M. Street</u>		Address <u>2528 B. Holman Ave. SS. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 1972 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of the pancreas + Uterus ampulla</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 months +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St.</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>September, 1967</u> , to <u>Nov. 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>November 13, 1967</u> , and that death occurred at <u>12:15</u> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Hugo G. Graziani</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI</u>				22d. ADDRESS <u>10101 GEORGIA AVENUE, SILVER SP. MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NORTH SIDE CATHOLIC CEM.</u>		23d. LOCATION (City, town or county) (State) <u>WESTVIEW TOWNSHIP, PITTSBURG PA.</u>	
24. FUNERAL DIRECTOR <u>H. Don. DeVol</u>				25a. REC'D BY REGISTRAR <u>W. A. R. C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>2222 W. 10th Ave. N.W.</u>				DATE <u>NOV 21 1967</u>			

00221

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15501

CERTIFICATE OF DEATH

15501

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (rural) c. LENGTH OF STAY IN It 33 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE PLAINS d. STREET ADDRESS RT#2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLIS Middle A Last ALBRIGHT		4. DATE OF DEATH Month NOV. Day 14 Year 19 67	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 SEPT. 1907
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. SERVICE USAF		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BERKELEY CO. W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM ALBRIGHT		14. MOTHER'S MAIDEN NAME SERABELL ARMBRASTEN Sara Belle Armbraster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 223 50 3505	
17. INFORMANT RUBY C. ALBRIGHT		Address RT#2 WHITE PLAINS MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the lung DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 12 OCT. 1967 , to 14 NOV. 1967 , that (1) (we) last saw the deceased alive on Nov. 14 19 67 , and that death occurred at 615 P M , from causes and on the date stated above.			
22a. SIGNATURE C. S. Reeves		22b. DATE SIGNED 16 Nov. 1967	
22c. PHYSICIAN'S NAME (Type) C. S. REEVES, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11-18-1967	23c. NAME OF CEMETERY OR CREMATORY ROSEDALE	23d. LOCATION (City or Town) (County) (State) MARTINSBURG W. VA.
24. FUNERAL DIRECTOR BROWN FUNERAL HOME		25a. REC'D BY REGISTRAR NOV 20 1967	
ADDRESS MARTINSBURG, W. VA.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

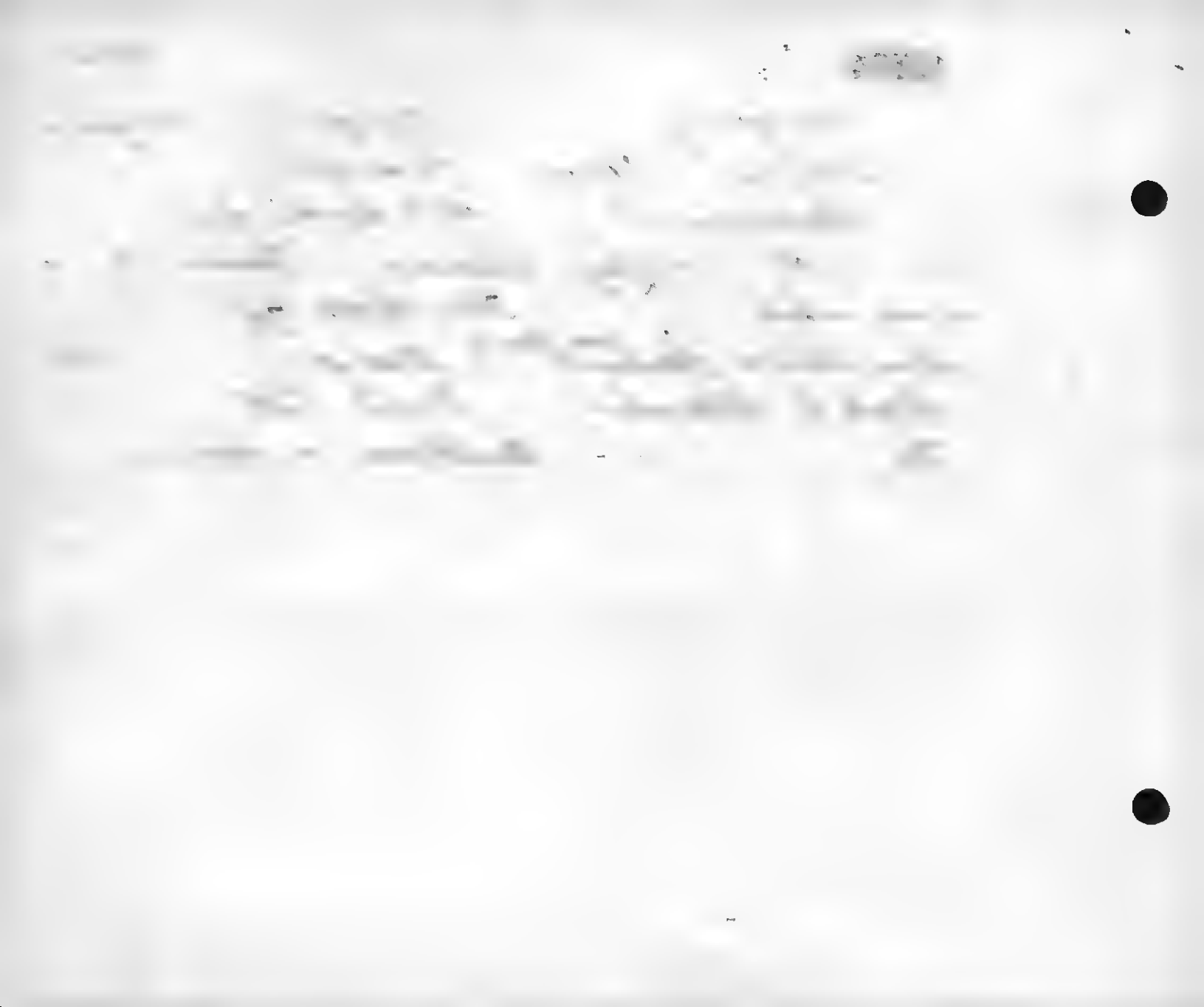
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15504

CERTIFICATE OF DEATH

15502

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY in TB <i>1 hour</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		d. STREET ADDRESS <i>4012 Franklin Street</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>A. Leroy Alderman</i>		4. DATE OF DEATH Month <i>November</i> Day <i>19</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 26/1892</i>
9. AGE (In years last birthday) <i>74</i> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Semi Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Automotive Trucking</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Michigan</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank E. Alderman</i>		14. MOTHER'S MAIDEN NAME <i>Carrie Pitt</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>577-09-9565</i>	
17. INFORMANT <i>Mrs. Alderman - above</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>42.21 Ventricular fibrillation</i> DUE TO (b) <i>Coronary atherosclerosis</i> DUE TO (c) <i>Heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>16 yrs.</i>	
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> , 19 to <i>1967</i> , that (I) (we) last saw the deceased alive on <i>Oct. 10</i> 19 <i>67</i> , and that death occurred at <i>20 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Bernard J. Walsh</i> M.D.		22b. DATE SIGNED <i>11/19/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Bernard J. Walsh</i>		22d. ADDRESS <i>1800 Eye St. N.W.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11-24-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Meadow Brook Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Milliken, Michigan</i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>NOV 24 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15503

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i> c. LENGTH OF STAY N 1b <i>DOA</i>		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
3. NAME OF DECEASED (Type or print) <i>Helen Holt Alexander</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>30</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-18-30</i>
9. AGE (In years last birthday) <i>47</i> yrs.		10. FUNDING YEAR Months <i>30</i> Days <i>19</i> Hours <i>67</i> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clocker</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Martin Holt</i>		14. MOTHER'S MAIDEN NAME <i>Cecile Rogers Holt</i>	
15. WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Mrs. Helen Holt Alexander</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1944/1/1 Pulmonary edema, intra alveolar hemorrhage</i> DUE TO (b) <i>Cardiac hypertrophy and dilatation</i> DUE TO (c) <i>Secondary anemia</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE <i>J. B. Ock</i>		22. DATE SIGNED <i>Dec 1 1967</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>12-9-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Family Plot</i>		23d. LOCATION (City or town) (County) (State) <i>Greensboro, N.C.</i>	
24. FUNERAL DIRECTOR <i>Catney Funeral Home 3831 2nd Ave NW Wash, DC</i>		25a. REC'D BY REGISTRAR <i>DEC 6 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

72321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15506 CERTIFICATE OF DEATH 15504											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 12 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4601 Harling Lane					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4601 Harling Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Mary Middle S. Last Allen			4. DATE OF DEATH Month Nov. Day 5, Year 19 67		5. SEX Female			6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wooster, Ohio			12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Joseph G. Sanborn					14. MOTHER'S MAIDEN NAME Kate E. Day						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-44-2079		17. INFORMANT Son Address Same as Item 2.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC INTESTINAL OBSTRUCTION 1108 DUE TO (b) CARCINOMA OF COLON Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OSTEO POROSIS SEVERE 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from OCT. 20, 1955 to Nov. 5, 1967 , that (I) (we) last saw the deceased alive on OCT. 31, 1967 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Robert G. Angle					22b. DATE SIGNED Nov. 5, 1967		22c. PHYSICIAN'S NAME (Type) ROBERT G. ANGLE				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 11-9-67		23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery		23d. LOCATION (City, town or county) (State) S. Fort Mitchell, Ky.		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR NOV 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				

10321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15507									
CERTIFICATE OF DEATH									
15565									
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if not at an Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>1</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			c. LENGTH OF STAY IN 7b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>					d. STREET ADDRESS <u>1806 6th St. N.W.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Allison</u> Last <u>Allison</u>					4 DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>1967</u>				
5 SEX <u>Fe</u>		6 COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/15/1884</u>		9. AGE (In years last birthday) <u>83</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-maker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Lawrens, S.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Charley Casey</u>					14. MOTHER'S MAIDEN NAME <u>Ella Glenn</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO <u>381-10-1950</u>		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Arteriosclerosis Hypertensive</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/1/67</u> , 19 <u>67</u> , to <u>NOV. 18</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/17/67</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above									
22a. SIGNATURE <u>Myron L. Luckert M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov 18, 1967</u>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL CREMATON, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/22/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>			23d. LOCATION (City or Town) (County) (State) <u>Landover, Maryland</u>		
24. FUNERAL DIRECTOR <u>W. Ernest Jarvis Co., Inc.</u> <u>Jarvis funeral home 1432 20th St N.W.</u>					25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15508

CERTIFICATE OF DEATH

15506

1 PLACE OF DEATH a. CO. JNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>1513 Erskine Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul Boghas Andonian</u>		4. DATE OF DEATH Month Day Year <u>November 8 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-96</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Helper, Hotel</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.D.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. BIRTHPLACE (County & State, or foreign country) <u>Turkey</u>	
13. FATHER'S NAME <u>Hagop Andonian</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Chulgian</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>018-07-0625</u>	
17. INFORMANT <u>Patient's chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO (b) <u>Cholangitis</u> DUE TO (c) <u>Chronic cholecystitis & cholelithiasis & choledocholithiasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Old pleurisy, recent cholecystectomy, pneumonia.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 3</u> , 19 <u>67</u> , to <u>Nov 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 7</u> , 19 <u>67</u> , and that death occurred at <u>5:30 A.</u> M., from causes and on the date stated above			
22a. SIGNATURE <u>W.W. Eastman</u>		22b. DATE SIGNED <u>Nov 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.W. Eastman</u>		22d. ADDRESS <u>831 Univ. Blvd. East, Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Nov. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, A.C.</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Inc. 8655 Ga. Ave. Silver Spring, Md</u>		25a. REC'D BY REGISTRAR <u>DATE NOV 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #26 & C 51m #3395 11/29/67 ph

15509

CERTIFICATE OF DEATH

15507

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c LENGTH OF STAY IN 1b <u>4 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>Path Hall, Locally Military Hwy</u>	
3 NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>M.</u> Last <u>ATHERTON, JR</u>		4 DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-9-96</u>
9 AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper - Credit Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Iowa - (Clinton)</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Atherton</u>		14. MOTHER'S MAIDEN NAME <u>Solia Hinton</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Navy</u>		16 SOCIAL SECURITY NO <u>578-48-0699</u>	
17 INFORMANT <u>Harry M. Atherton, JR 11717 Enid Dr.</u>		Address <u>Rockville, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO (b) <u>Pulmonary insufficiency</u> DUE TO (c) <u>Bilateral pneumonia, probably aspiration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sev. hours</u> <u>sev. days</u> <u>sev. days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, electrolyte imbalance, generalized arteriosclerosis</u>		19 WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>64</u> , to <u>Nov 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 20</u> , 19 <u>67</u> , and that death occurred at <u>2:50</u> A.M. from causes and on the date stated above.			
22a SIGNATURE <u>George H. Mitchell</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11/21/67</u>	
22c PHYSICIAN'S NAME (Type) <u>George H. MITCHELL</u>		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11-24-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a REC'D BY REGISTRAR	
25b REGISTRAR'S SIGNATURE <u>Richard J. Judge</u>		DATE <u>NOV 24 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. This should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Discovered & Cleared with Hunt Co. Med. Examiner

MEDICAL CERTIFICATION

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c LENGTH OF STAY IN 1b Sandy Spring	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e STREET ADDRESS 13230 Rockville Pike	
3 NAME OF DECEASED (Type or print) Rueben Lamar Baker		4 DATE OF DEATH 11 18 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/26/86
9 AGE (In years last birthday) 81 yrs		10 IF UNDER 1 YEAR Months 11 Days 18 Hours 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY Retired	
11 BIRTHPLACE (County & State, or foreign country) Md.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Tyson Baker		14 MOTHER'S MAIDEN NAME Edith Sullivan	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. 214 03 0710	
17 INFORMANT Edith Sullivan		Address 13230 Rockville Pike	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7201 DUE TO ACUTE MYOCARDIAL DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO CORONARY ATHEROSCLEROSIS GEN'L ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH YES YES	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS - HYPERTENSION		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Aug 1964 to 11/18 1967 , that (I) (we) last saw the deceased alive on 11/18 1967 ; and that death occurred at 6:10 PM from causes and on the date stated above			
22a SIGNATURE Donald Lewis		22b DATE SIGNED 11/19/67	
22c PHYSICIAN'S NAME (Type) Donald Lewis MD.		22d ADDRESS Sandy Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) 11/21/67		23b DATE THEREOF 11/21/67	
23c NAME OF CEMETERY OR CREMATORY Colesville Meth. Cem.		23d LOCATION (City or Town) (County) (State) Colesville Md.	
24. FUNERAL DIRECTOR Tyson Heller P. H. 1331 Rockville Pike		25a REC'D BY REGISTRAR DATE NOV 24 1967	
25b REGISTRAR'S SIGNATURE James Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared - medical examiner

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15511

CERTIFICATE OF DEATH

15509

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 1409 Langley Way	
3 NAME OF DECEASED (Type or print) First Harry Middle none Last Barick		4 DATE OF DEATH Month 11 Day 9 Year 1967	
5 SEX male	6 COLOR OR RACE Caus.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/22/1896
9 AGE (in years lost, birthday) yrs. 71		10 UNDER 1 YEAR Months Days 11 UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Office Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York, N.Y.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rayfield Barick		14. MOTHER'S MAIDEN NAME Rebecca	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 073-34-3958	
17 INFORMANT Nursing Home Records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction +201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive arteriosclerotic heart disease DUE TO (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basilar artery cerebral thrombosis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January, 1967 to 11-9, 1967 that (I) (we) last saw the deceased alive on 11-8-67 1967 and that death occurred at 10:00 M., from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 11-9-67	
22c. PHYSICIAN'S NAME (Type) Jason Geiger, M.D.		22d. ADDRESS 800 Pershing Dr., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-12-67	23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery	23d. LOCATION (City or town) (County) (State) Deans, I.D.
24. FUNERAL DIRECTOR <i>[Signature]</i>		25a. REC'D BY REGISTRAR NOV 10 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15512

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15510

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		d. STREET ADDRESS 506 DENHAM ROAD	
3. NAME OF DECEASED (Type or print) MICHAEL REID BARRETT II		4. DATE OF DEATH Month NOV. Day 12 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 3, 1967
9. AGE (In years, last birthday) yrs 8 Months 6 Days 6 Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ALABAMA	
13. FATHER'S NAME MICHAEL REID BARRETT I		14. MOTHER'S MAIDEN NAME CHERYL MARDIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO -----	
17. INFORMANT MICHAEL REID BARRETT I FATHER		Address SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Primary Cause: 2. At 12:00 AM DUE TO (b) Viral Pneumonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2+0
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 8)	
20c. TIME OF INJURY Month, Day, Year Hour 19 m. pm	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John F. Bell		22. DATE SIGNED 11/14/67	
EXAMINER'S NAME (Type) John F. Bell Bethesda, Md.		Address (Street, city, town, or county) Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/13/67	23c. NAME OF CEMETERY OR CREMATORY Gadsden, Alabama	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR NOV 14 1967	25b. REGISTRAR'S SIGNATURE Charles Jones

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>St. Georges</u>	
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>Takoma Park</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		d STREET ADDRESS <u>422 Lincoln Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>David Louis Baxter</u>		4 DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-13-13</u>
		9 AGE (In years last birthday) <u>54</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Defense Dept</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>	
11 BIRTH PLACE (State or foreign country) <u>Petersburg, Virginia</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13 FATHER'S NAME <u>Charles Baxter</u>		14 MOTHER'S MAIDEN NAME <u>Larice</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW II</u>		16 SOCIAL SECURITY NO <u>223 14 3794</u>	
17 INFORMANT (WIFE) <u>Mrs Katherine M Baxter (same as #2)</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Insufficiency</u>			
(b) <u>Coronary Artery Heart Disease</u>			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. pm <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>Nov. 18, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Wheaton</u> (County) <u>MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Nov. 20, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Baltimore MD</u>
24. FUNERAL DIRECTOR <u>John W. Miller</u>		25a RECD BY REGISTRAR <u>Nov 21 1967</u>	
ADDRESS <u>284 Carroll St NW Washington DC</u>		25b REGISTRAR'S SIGNATURE <u>John W. Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15514

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15512

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN 1b 29 Days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d STREET ADDRESS 6509 OLD STAGE RD	
3 NAME OF DECEASED (Type or print) First MIDDLE Last HENRY R. BRYEN		4 DATE OF DEATH Month NOV. Day 7 Year 1977	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/17/77
9 AGE (In years lost birthday) 90 yrs		FUNDER 1 Year Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BARBER		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) WISCONSIN		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME CARL BECKMAN		14 MOTHER'S MAIDEN NAME ANNA BEYER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 318-09-6930A	
17 INFORMANT SON MORRIS - SAME		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4500 Cardiac Failure DUE TO (b) Generalized arteriosclerosis DUE TO (c) 20 yrs.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. pm 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 10/17 , 19 67 , to 11/7 , 19 67 , that (I) (we) last saw the deceased alive on 11/7 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above.			
22a SIGNATURE Ronald		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) on 11 " . B rr		22d ADDRESS 1041 Old Georgetown Road, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 11/11/67	23c NAME OF CEMETERY OR CREMATORY New Lisbon Cemetery	23d LOCATION (City or Town) (County) (State) New Lisbon, Wisconsin
24 FUNERAL DIRECTOR Theron Hepler Funeral Home		25a REC'D BY REGISTRAR NOV 9 1967	
25b REGISTRAR'S SIGNATURE Charles J. J...			

VR A15 (4)
25M 1/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15515

CERTIFICATE OF DEATH

15513

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY 1 ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 6223 Fernwood Terrace	
3 NAME OF DECEASED (Type or print) Randall Leland Kirp Bereano		4 DATE OF DEATH Month November Day 9 Year 19 67	
5. SEX Male	6. COLOR OR RACE Caucasian	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9 November 1967
9 AGE (In years lost birthday) yrs 15		IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Philip L. Bereano		14. MOTHER'S MAIDEN NAME Nancy Dee Kirp	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 0 (If yes give war or dates of service)		16 SOCIAL SECURITY NO. None	
17 INFORMANT Philip L. Bereano, Riverdale, Maryland		18 ADDRESS 6223 Fernwood Terrace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 7600 IMMEDIATE CAUSE (a) Atelectasis, Lungs, Etiology Unknown DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that X (this hospital) attended the deceased from 6:31am, 9 Nov. 1967 , to 10:30PM, 9 Nov 1967 , that X (we) last saw the deceased alive on 9 November 1967 , and that death occurred at 9:30PM , from causes and on the date stated above.			
22a SIGNATURE G. P. Swartz		22b. DATE SIGNED 11 November 1967	
22c PHYSICIAN'S NAME (Type) G. P. Swartz		22d ADDRESS Naval Hospital, Bethesda, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 11-12-1967	23c NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery	23d LOCATION (City or Town) (County) (State) Woodbridge, New Jersey
24 FUNERAL DIRECTOR Goldberg Funeral Home, Washington, D.C.		25a REC'D BY REGISTRAR DATE NOV 13 1967	25b REGISTRAR'S SIGNATURE O. Charles Jones

15516

15514

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Brooklyn</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> d. STREET ADDRESS <u>255 Troy Avenue</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>Bern</u> Last <u>Bern</u>			4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>19 67</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/17/98</u>	9. AGE (In years lost birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>Menosha Bernstein</u>			14. MOTHER'S MAIDEN NAME <u>Ethel Schwartz</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>		17. INFORMANT <u>Mr. Ellis Berne</u> Address <u>9209 Whitney Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary aortic thrombosis - myocardial infarction</u> DUE TO (b) <u>infection</u> DUE TO (c) <u>congestive failure (pulmonary edema)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic atherosclerotic cardiovascular disease</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/4/</u> , 19 <u>67</u> , to <u>11/14/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/14/</u> 19 <u>67</u> , and that death occurred at <u>8:30 PM</u> , from causes and on the date stated above					
22a. SIGNATURE <u>Donald M. Stein</u> M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>11/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald M. Stein</u>			22d. ADDRESS <u>7501 11th St N.W. Washington D.C. 20012</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beth David Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Long Island, New York</u>	
24. FUNERAL DIRECTOR <u>Donald M. Stein</u> <u>Hebrew Memorial Funeral Home</u>			ADDRESS <u>232 Carroll Wash DC 20012</u>		25a. REC'D BY REG-STRAR <u>NOV 17 1967</u>
			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

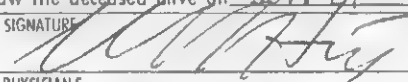

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15517

CERTIFICATE OF DEATH

15515

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hialeah	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 948 West 79th Street	
3 NAME OF DECEASED (Type or print) First Middle Last John Richard BERRIOS		4 DATE OF DEATH Month Day Year November 27 1967	
5 SEX Male	6 COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1947
9 AGE (In years last birthday) yrs 19		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps	
11 BIRTHPLACE (County & State or foreign country) New York City, N. Y.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ralph Berrios		14. MOTHER'S MAIDEN NAME Mrs. Inez M. Malgrat	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1966-1967		16 SOCIAL SECURITY NO 267 80 9453	
17 INFORMANT Hialeah, Florida Mr. John Ralph Berrios, 948 West 79th St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage DUE TO (b) Multiple gunshot wounds to abdomen DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Rifle shots received Da Nang, South Viet Nam	
20c. TIME OF INJURY Month, Day, Year Hour am p.m. 300 26 Aug 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work or work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) 30 miles south Da Nang
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 20, 1967 to Nov. 27, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 27, 1967 , and that death occurred at 420A M. from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED Nov. 28, 1967	
22c. PHYSICIAN'S NAME (Type) W.R. HIX M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/1/67	23c. NAME OF CEMETERY OR CREMATORY Vista Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Hialeah, Florida
24. FUNERAL DIRECTOR Falls Church Funeral Home 1102 West Broad Street, Falls Church, Va.		25a. REC'D BY REGISTRAR DEC 1 1967	25b. REGISTRAR'S SIGNATURE 



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15516

15519

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>22 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8000 Blair Mill Road</u>				d. STREET ADDRESS <u>8000 Blair Mill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Myra</u> Middle <u>E</u> Last <u>Black</u>				4 DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>19 67</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 13, 1897</u>		9 AGE (In years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Asst. Exec. Sec. TransWorld Air.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Aaron Black</u>				14. MOTHER'S M maiden NAME <u>Collins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>577-03-6970</u>		17. INFORMANT <u>Mrs. Frances H. Jabant-Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> 203X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>pm</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				22. DATE SIGNED <u>Nov. 27, 1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 29, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>	
Funeral Director's Name <u>Thomas H. Warner E. Humphrey, Inc.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>DEC 1 1967</u>	



15519

CERTIFICATE OF DEATH

15517

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. SAN.		d. STREET ADDRESS 8210-N. Hamp. Ave.	
3 NAME OF DECEASED (Type or print) Rose Blumenthal		4. DATE OF DEATH November 23 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH OCT-20-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	11 BIRTHPLACE (County & State or foreign country) HUNGARY
13 FATHER'S NAME ADOLPH MANN		14 MOTHER'S MAIDEN NAME ELIZABETH (UNK.)	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO. 577-10-1957D	17. INFORMANT MAURICE H. WARSAW (same as 2a)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) bronchopneumonia DUE TO (b) atherosclerotic heart disease DUE TO (c) with implanted pacemaker			INTERVAL BETWEEN ONSET AND DEATH 2 days years 9 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 1967, to Nov-23 , 1967, that (I) (we) last saw the deceased alive on Nov-22 , 1967, and that death occurred at 7:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Sydney Leventhal		22b. DATE SIGNED Nov-23, 1967	
22c. PHYSICIAN'S NAME (Type) Sydney Leventhal, M.D.		22d. ADDRESS Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/26/67	23c. NAME OF CEMETERY OR CREMATORY B'NAI ISRAEL Cem.	23d. LOCATION (City or town) (County) (State) OXON HILL, MD.
24 FUNERAL DIRECTOR GOLDBERG		25a. REC'D BY REGISTRAR DATE NOV 27 1967	
25b. REGISTRAR'S SIGNATURE W. Lawrence Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Approved by Dr. Sydney Leventhal

1000



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15520

15518

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>M</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>		d. STREET ADDRESS <u>169 Elm Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Milton</u> First <u>Bollman</u> Middle <u>Bollman</u> Last		4 DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-7-1887</u>
9 AGE (In years last birthday) <u>80</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>BEILDING</u>		11 BIRTHPLACE (County & State, or foreign country) <u>OAKLAND, CALIFORNIA</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13 FATHER'S NAME <u>CALVIN P. BOLLMAN</u>	
14 MOTHER'S MAIDEN NAME <u>PITILENA ROBINSON</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
16 SOCIAL SECURITY NO. <u>578 46 5499</u>		17 INFORMANT <u>ARTHUR W. BOLLMAN</u> Address <u>(SAME AS #2)</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>334X</u> IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>10-17, 1967</u> , to <u>11-20, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-20, 1967</u> , and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>R.C. Kirchner</u>		22b DATE SIGNED <u>11-20-67</u>	
22c PHYSICIAN'S NAME (Type) <u>R.C. KIRCHNER M.D.</u>		22d ADDRESS <u>6480 N.H. AVE. TAKOMA PARK, Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>Nov. 24-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Leo Oak Con. Lymn Rd. & Res. Md</u>	23d LOCATION (City or town) (County) (State)
24 FUNERAL DIRECTOR <u>Arthur Walters Washington, D.C. 20012</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15521

CERTIFICATE OF DEATH

15519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN b. <i>33 hours</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		2 USUAL RESIDENCE (Where deceased lived, 1 institution, 2 Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> d. STREET ADDRESS <i>6435 Burke Lane</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Ralph F. Boase</i>		4 DATE OF DEATH Month <i>Nov.</i> Day <i>28</i> Year <i>1967</i>	
5 SEX <i>M.</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>5/9/07</i>
9. AGE (In years last birthday) yrs <i>60</i>		10. US. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Edward Henry Boase</i>	
14. MOTHER'S MARDEN NAME <i>Margaret King</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO <i>579-03-1581</i>		17. INFORMANT <i>Wife - Freda - Same</i>	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <i>10/30, 1967</i> to <i>present</i> , 19__, that (2) (we) last saw the deceased alive on <i>11/28, 1967</i> , and that death occurred at <i>11p</i> M, from causes and on the date stated above			
22a. SIGNATURE <i>John B. Umhau MD</i>		22b. DATE SIGNED <i>11/29/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN B. UMHAU MD</i>		22d. ADDRESS <i>8805 Conn. Ave. Chevy Chase, Md</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-2-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Prince George County, Md.</i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>DEC 4 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>William Judge</i>			

1951

1951



15522

CERTIFICATE OF DEATH

15520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONT.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONT.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN ID <u>19 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>5901 Spaatz Place</u> <u>Rockville</u>	
3. NAME OF DECEASED (Type or print) First <u>HIRAM</u> Middle <u>A.</u> Last <u>BOUCHER</u>		4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/96</u>
9. AGE (in years lost birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>9</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Foreign Service Dept. of State</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of State</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>South Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO <u>220-44-0421</u>	
17. INFORMANT <u>Valerie Boucher</u>		<u>30 Platanna Court, N.W.</u> <u>Washington, D. C. Rm. 309</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory</u> DUE TO <u>Bilateral pulmonary pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pulmonary Emphysema</u> (c) <u>Chronic Pulmonary Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Chronic Pulmonary Emphysema</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 19 <u>59</u> , to <u>11-9</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>11/8</u> , 19 <u>67</u> , and that death occurred at <u>6:55 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Barton J. Gershen</u>		22b. DATE SIGNED <u>11/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Barton J. Gershen</u>		22d. ADDRESS <u>50 West Edmonston Dr. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. ADDRESS <u>8434 Georgia Avenue</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>NOV 15 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Discharge & clear by Dr. B. B. Reap

15522

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst't on Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 9305 Long Branch Pkwy.	
3. NAME OF DECEASED (Type or print) James (none) Brothwell		4. DATE OF DEATH Month November Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/77
9. AGE (In years lost birthday) 90 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Transportation	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Brothwell		14. MOTHER'S MAIDEN NAME Elizabeth SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 038-22-2505	
17. INFORMANT Daughter, Address Marion Bower 9305 Long Br. Pkwy. S.S., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) " arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov , 19 62 , to Nov. 17 , 19 67 , that (I) (we) lost saw the deceased alive on Nov 12 , 19 67 , and that death occurred at 9:15 M, from causes and on the date stated above.			
22a. SIGNATURE A. F. Thibadeau		22b. DATE SIGNED 11/17/67	
22c. PHYSICIAN'S NAME (Type) A. F. THIBADEAU		22d. ADDRESS Silver Spring, Md	
23a. B. RIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-21-67	23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Bladensburg Md
24. FUNERAL DIRECTOR W. W. Chambers 640 Silver Spring Md		25a. REC'D BY REGISTRAR NOV 20 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

15524

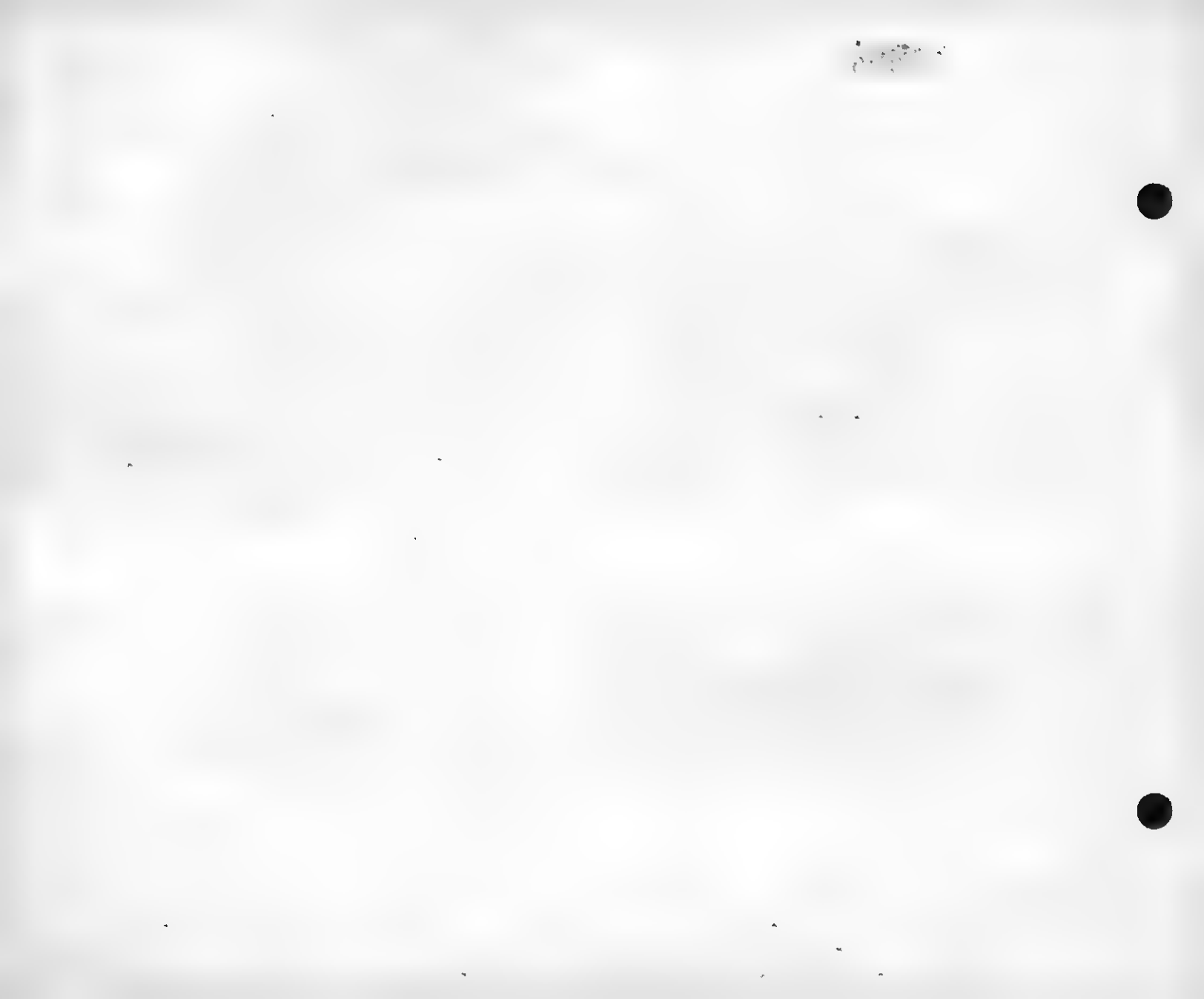
CERTIFICATE OF DEATH

15522

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY in lb <u>7 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susan Gay Buell</u>		4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/43</u>
9. AGE (In years last birthday) <u>24</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S</u>	
13. FATHER'S NAME <u>C. E. Render</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bradley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Alden W. Buell</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremic Syndrome & Pseudomonal Pyelonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 months days</u>	
(b) <u>Lupus Nephritis - Malignant Hypertension</u>		<u>2 years - 3 months</u>	
(c) <u>Systemic Lupus Erythematosus</u>		<u>8-10 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>65</u> , to <u>November 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov - 7</u> , 19 <u>67</u> , and that death occurred at <u>3:20</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Hugo G. Graziani</u>		22b. DATE SIGNED <u>11/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI, M.D.</u>		22d. ADDRESS <u>1101 GEORGIA AVE, SS. MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 10 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
25M 1/67

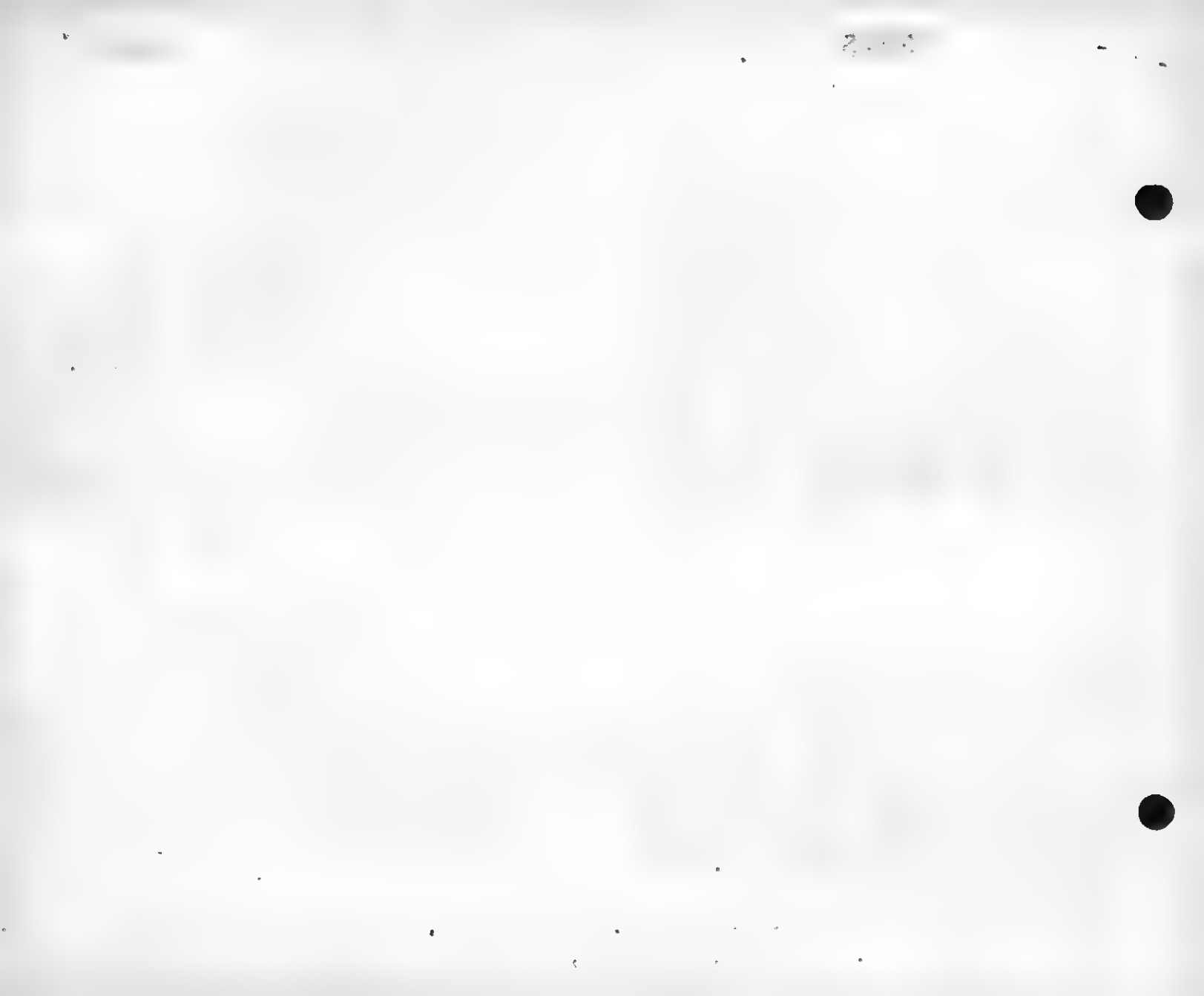
15525

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15523

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>23 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> d. STREET ADDRESS <u>9205 EAST PARK HILL DR</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>CARL R. Bullock</u>		4. DATE OF DEATH Month Day Year <u>Nov 20 1967</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/19/09</u>
9 AGE (In years last birthday) <u>58 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept of Agriculture</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CAIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William H Bullock</u>		14. MOTHER'S MAIDEN NAME <u>MOLLY McDaniel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>17. INFORMANT</u> <u>MARY Bullock - WIFE - SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MALIGNANT CACHEXIA, due to</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>LIPOSARCOMA, RETROPERITONEAL</u> DUE TO (c) <u>6 MONTH</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>SEPT 7</u> , 1954, to <u>NOV. 20</u> , 1967, that (I) (we) last saw the deceased alive on <u>NOV. 20</u> , 1967, and that death occurred at <u>12:05 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Robert G. Angle</u>		22b. DATE SIGNED <u>NOV. 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		22d. ADDRESS <u>5009 Del Ray Ave. Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-22-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Prince George County, Md.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15528

CERTIFICATE OF DEATH

15524

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>30 years</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>1574 East West Highway</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>1574 East West Highway</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Bertha</i> Last <i>Burke</i>			4. DATE OF DEATH Month <i>November</i> Day <i>9</i> Year <i>1967</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 14, 1896</i>	9. AGE (In years last birthday) <i>70</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Executive-Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Newfoundland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			13. FATHER'S NAME <i>Martin Burke</i>				
14. MOTHER'S MAIDEN NAME <i>Nora Murphy</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. <i>001-09-6101 A</i>			17. INFORMANT <i>Mrs. Francis E. Mc Ardle</i> Address <i>1574 East West Highway Silver Spring, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO (b) <i>Essential Hypertension</i> DUE TO (c) <i>5 yrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <i>one day</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <i>August 1948</i> to <i>11/8</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11/8</i> , 19 <i>67</i> , and that death occurred at <i>12</i> M., from the causes and on the date stated above.							
22a. SIGNATURE <i>William T. Saccardi</i> M.D.			22b. DATE SIGNED <i>11/11/67</i>	22c. PHYSICIAN'S NAME (Type) <i>William T. Saccardi</i>			
22d. ADDRESS <i>1150 Conn. Ave. N.W. WASH. D.C.</i>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Rural</i>	23b. DATE THEREOF <i>Nov. 14, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Roslindale, Mass.</i>				
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		24a. ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>	24b. REC'D BY REGISTRAR <i>NOV 15 1967</i>		24c. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>		

15527

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15525

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>METHESDA</u>		c. LENGTH OF STAY IN 1b <u>2 MONTHS + ROAD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOYDS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				d. STREET ADDRESS <u>Hwy #1 121 Box 19</u>			
3. NAME OF DECEASED (Type or print) <u>BURCHYL S. BURNETTE</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/5/05</u>		9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHILTON CO.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN B. BURNETTE</u>				14. MOTHER'S MAIDEN NAME <u>NANCY SHARLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>067-10-8953</u>		17. INFORMANT <u>EVELYN BURNETT-WILIE</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>ACUTE CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ANOXIA-POSTOP. COMPLICATIONS- LUNG RESECTION</u> DUE TO <u>BRONCHIAL CARCINOMA (POSTOPERATIVE)</u> (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUG</u> , 1967, to <u>NOV. 18</u> , 1967, that (I) (we) last saw the deceased alive on <u>NOV. 18</u> , 1967, and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>JOSEPH W. PEABODY JR.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH W. PEABODY JR. M.D.</u>				22d. ADDRESS <u>1234 19th St. N.W. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Md.</u>	
24. FUNERAL DIRECTOR <u>Myson Wheeler</u>				25a. REC'D BY REGISTRAR <u>NOV 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon flaps, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15528

15526

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Springs</u>	
c. LENGTH OF STAY IN 1b <u>2 months</u>		d. STREET ADDRESS <u>315 Leighton Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Riggs Bussard</u>		4 DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-18-10</u>
9 AGE (In years lost birthday) <u>57</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P. C. Transit</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Louis Bussard</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Manakoe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOC. A. SECURITY NO. <u>unknown</u>	
17 INFORMANT <u>Father Bussard</u> Address <u>315 Leighton Avenue Hospital chart Silver Spring, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>terminal multiple myeloid complication</u> DUE TO (b) <u>lymphoma degeneration</u> DUE TO (c) <u>7 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1967</u> , to <u>Nov 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 18, 1967</u> , and that death occurred at <u>6:30 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Hugh J. J...</u>		22b DATE SIGNED <u>11/22/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Hugh J. J...</u>		22d ADDRESS <u>11161 New Hampshire Ave., Silver Spring</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>Nov 21, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md.</u>
24. FUNERAL DIRECTOR <u>W. J. J...</u> ADDRESS <u>4334 Georgia Avenue Silver Spring, Maryland</u>		25a REC'D BY REGISTRAR <u>NOV 22 1967</u>	25b REGISTRAR'S SIGNATURE <u>John J. J...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18, Film #395 12-12-67 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15522											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital						d. STREET ADDRESS 4701 Saul Road				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Timothy Oberem Callagy						4. DATE OF DEATH Month Day Year November 24 19 67					
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1967		9. AGE (In years last birthday) yrs 7 Months 11 Days		10. IF UNDER 1 YEAR Hours Min 24 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David W. CALLAGY						14. MOTHER'S MAIDEN NAME Joan Mary Oberem					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. no		17. INFORMANT David W. Callagy, Address, Father, 4701 Saul Road, Kensington, Maryland					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3710 MENINGOENCEPHALITIS - H. Influenzae DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) 85 MINUTES										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12 NOV , 19 67 ; Nov. 24 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 24 , 19 67 , and that death occurred at 10:35 AM , from causes and on the date stated above.											
22a. SIGNATURE [Signature]						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 25 NOV 1967			
22c. PHYSICIAN'S NAME (Type) LT G.P. SWARTZ, MC, USN						22d. ADDRESS NAVAL HOSPITAL, BETHESDA MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 11/27/67		23c. NAME OF CEMETERY OR CREMATORY State of Md. n				23d. LOCATION (City or Town) (County) (State) Silver Spring Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Rockville, Maryland						25a. REC'D BY REGISTRAR DATE NOV 28 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. This 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

15530

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #11, 12, 13, & 14. File # 7336 12/6 1/17 m

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15528

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>1</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>DOA</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hospital</u>		d STREET ADDRESS <u>1407 1/2 Merrimac Dr.</u>	
3 NAME OF DECEASED (Type or print) <u>Eugene Calloway</u>		4 DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>C.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-23-46</u>
9 AGE (in years last birthday) <u>21</u> yrs		10 IF UNDER 1 YEAR F UNDER 24 HRS Months Days Hours Min	
10a USUA. OCCUPATION (Give kind of work done during most of working life even if retired) <u>janitor</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Washington, Georgia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Frank Calloway</u>		14 MOTHER'S MAIDEN NAME <u>Hattie Mays</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Exsanguination (Hemothorax)</u> DUE TO <u>due to gunshot wound in</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Chest.</u> DUE TO <u></u> (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19 WA. A. TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1(a) from 18)	
20c TIME OF INJURY Month, Day, Year <u>9:50 PM 11-8-1967</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (home, farm, factory, street, office bldg, etc.) <u>Yard</u>		20f (City or town) <u>Hyattsville, Prince Georges, Md</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above. Held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>11/8/67</u>	
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELODEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>		Address (Street, City or Town, State) <u>Washington, Ga.</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11-12-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Washington</u>	23d LOCATION (City or town) (County) (State) <u>Washington, Ga.</u>
24 FUNERAL DIRECTOR <u>Washington Funeral Chapel</u>		25a REC'D BY REGISTRAR <u>NOV 15 1967</u>	
ADDRESS <u>475- H St. N.W. D.C.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15531

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15529

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY Fairfax ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. STREET ADDRESS 5224 Kepler Lane	
3. NAME OF DECEASED (Type or print) MONA VIVIAN CAPPARELL		4. DATE OF DEATH Month November 2, 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/12
9. AGE (in years last birthday) 55 yrs		10. F UNDER 1 YEAR Months Days 11. F UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor, Passport Div, State Dept.		10b. KIND OF BUSINESS OR INDUSTRY Missouri	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME E.J. Armstrong		14. MOTHER'S MAIDEN NAME Mary Worden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO	
17. INFORMANT Thomas Capparell-husband		Address (Add. same as above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fat embolism, pulmonary and cerebral DUE TO Multiple fractures and lacerations Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) Automobile Accident		INTERVAL BETWEEN ONSET AND DEATH 11 days 12 days 12 days	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Car ran off highway hitting utility pole	
20c. TIME OF INJURY Month, Day, Year Hour 7:25 am 10/22 19 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) highway	20f. (City or town) (County) (State) Bethesda Montgomery Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John H. Ball M.D.		22. DATE SIGNED 11/2/67	
EXAMINER'S NAME (Type) John H. Ball		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4 Nov 1967	23c. NAME OF CEMETERY OR CREMATORY Stewartsville Cemetery	23d. LOCATION (City or Town) (County) (State) Stewartsville, Mo.
24. FUNERAL DIRECTOR Charles Judge Ives Funeral Home, Inc. Arlington, Va.		25a. REC'D BY REGISTRAR DATE NOV 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MONTGOMERY STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>15-1</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hospital</u>		d STREET ADDRESS <u>1110 Ruppert Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Arthur Elliott Carleton</u>		4 DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-27-87</u>
9 AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months <u>2</u> Days <u>6</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	
11 BIRTHPLACE (State or foreign country) <u>England</u>		12 CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13 FATHER'S NAME <u>John Carleton</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>577-01-9228</u>	
17 INFORMANT <u>Dorothy Sheppard</u>		Address <u>1110 Ruppert Rd. Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Acute bronchopneumonia associated</u>			
DUE TO (b) <u>with acute and chronic pyelonephritis</u>			
DLE TO (c) <u>lost</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22 DATE SIGNED <u>Nov. 26, 1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Nov. 28, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d LOCATION (City or town) (County) (State) <u>Prince Georges County, Md.</u>	
24a FUNERAL DIRECTOR <u>Warner C. Humphrey, Inc.</u>		24b ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>	
25a REC'D BY REGISTRAR <u>Nov 28 1967</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15533

CERTIFICATE OF DEATH

15531

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: <u>Retired in private residence</u>) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb. <u>10 days/23 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		d. STREET ADDRESS <u>2 W Deer Park Dr Apt 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Edith</u> Middle <u>Carter</u> Last		4. DATE OF DEATH <u>November 20</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1893</u> 3-24- 1893 <u>1893</u> 9. AGE (In years <u>74</u> yrs)
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John HOWES</u>		14. MOTHER'S MAIDEN NAME <u>Helen Marie Gaither</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-03-9155</u>	
17. INFORMANT <u>Hospital Records</u> Address <u>7600 Carroll Ave. PK</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular disease</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u> <u>Chronic Renal Insufficiency</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9 Nov</u> , 19 <u>67</u> to <u>20 Nov</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>30 Apr</u> , 19 <u>67</u> and that death occurred at <u>7:30 p.m.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Thomas P. Fogarty</u> M.D.		22b. ADDRESS <u>1011 University Blvd E, Silver Spring, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas P. Fogarty M.D.</u>		22d. ADDRESS <u>1011 University Blvd E, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg Montgomery Md.</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> ADDRESS <u>S.S. Md.</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey Inc. 8434 Georgia Avenue</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey</u>		25c. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>	

15534

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

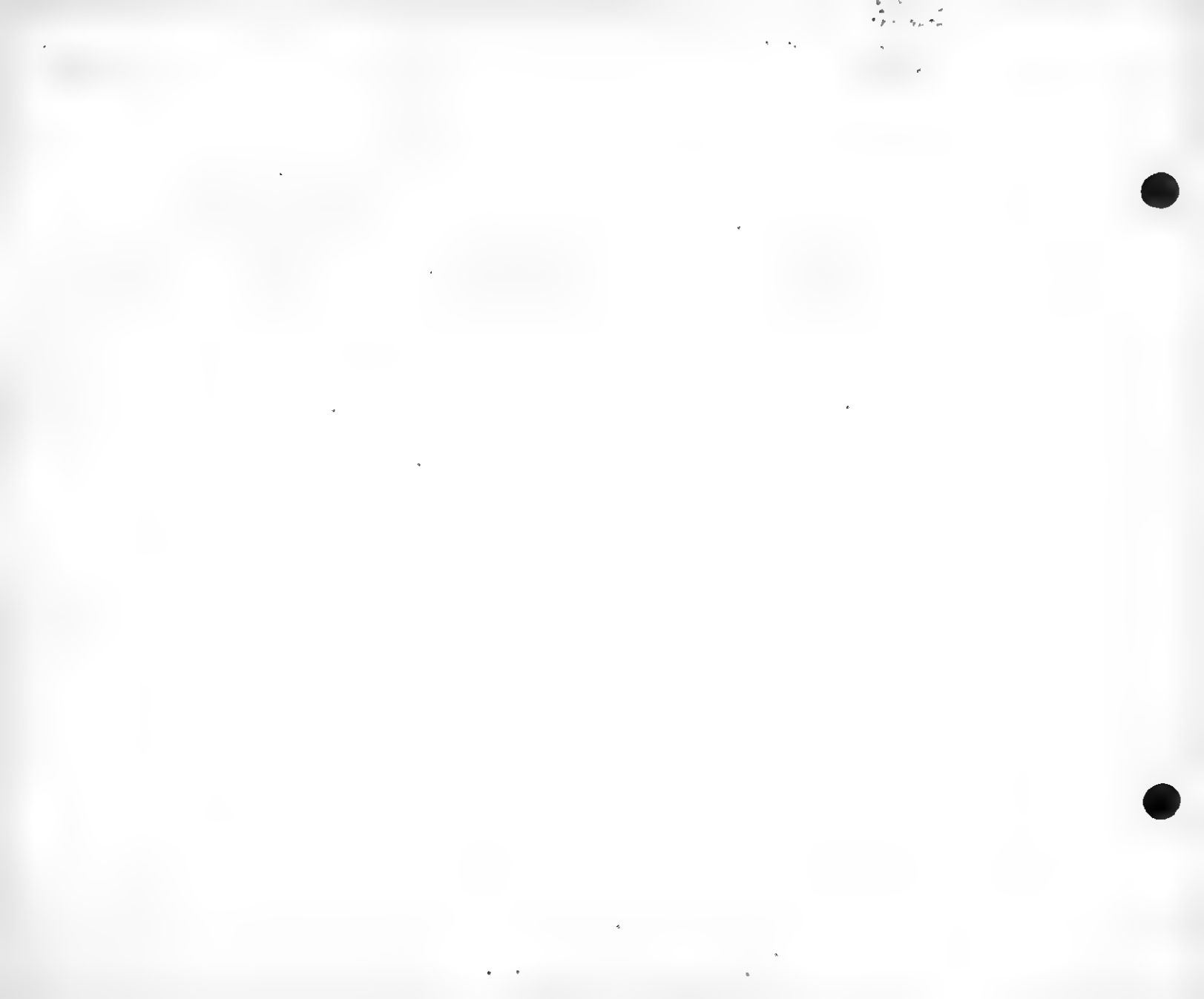
15532

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MD b COUNTY MONTGOM.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c LENGTH OF STAY in 1b SILVER SPRING	
d NAME OF HOSPITAL, OR INSTITUTION (if not hospital, give street address) 9008 FAIRVIEW ROAD		d STREET ADDRESS 9008 FAIRVIEW RD.	
3 NAME OF DECEASED (Type or print) First JAMES Middle P. Last CASBARIAN		4 DATE OF DEATH Month Nov. Day 25 Year 1967	
5 SEX M	6 COLOR OR RACE CAUC	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/16/1900
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chairman of Board & President Southern Md. Bank & Trust Co.		10b KIND OF BUSINESS OR INDUSTRY Maryland	
13 FATHER'S NAME Boghus G. Casbarian		14 MOTHER'S MAIDEN NAME Carrie L. Wilfong	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Harvey T. Casbarian Sherwood Forest, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Artery Heart Disease (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED Nov. 25, 1967		Address (Street, City, town, county)	
23a BURIAL, CREMATION, REMOVAL (Specify) burial	23b DATE THEREOF 11/28/67	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d LOCATION (City or Town) (County) (State) Prince Georges County, Md.
24 FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.		25a REC'D BY REGISTRAR NOV 29 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
15533 CERTIFICATE OF DEATH 15533									
Reg. Dist. No.									
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home					d. STREET ADDRESS 11307 Orleans Way				
3. NAME OF DECEASED (Type or print) First ALICE Middle L. Last CHARLES					4 DATE OF DEATH Month November Day 5 Year 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 12, 1888		9. AGE (In years lost birthday) yrs. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Lowell					14. MOTHER'S MAIDEN NAME Alice Canty				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 577-10-1960		17. INFORMANT Mary Mc Carthy, Friend, Same as # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uronea 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 5 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1942 , 19 11-5 , 19 67 , that I last saw the deceased alive on 11-4 , 19 67 , and that death occurred at 7:40 P.M., from the causes and on the date stated above.									
ACTUAL SIGNATURE James J. Burns M.D.					ADDRESS (Street, city or town, state) 1835 1st NW, WASH. D.C. 20006				
DATE SIGNED 11-5-67									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/8/67		22c. NAME OF CEMETERY OR CREMATORY Washington National Cem.			22d. LOCATION (City, town, or county) (State) Suitland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Washington, D.C. 20016					24a. REC'D BY REGISTRAR DATE NOV 9 1967		24b. REGISTRAR'S SIGNATURE Charles Judge		

15536

CERTIFICATE OF DEATH

15536

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 12 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE IOWA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SL OAN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. SAN. & Hosp.				d. STREET ADDRESS NONE		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN, SERENA CHRISTIANSON				4. DATE OF DEATH Month NOV Day 2 Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-'07		9. AGE (In years lost birthday) 60 yrs		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. BROWN				14. MOTHER'S MAIDEN NAME MARY RUTH MANN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO 481343851		17. INFORMANT (BROTHER) Joseph W. Brown Address 1220 Blair Mill Road, Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE INTRA CEREBRAL HEMMORRAGE DUE TO 551A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 4 DAYS DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/29, 1967 to 11/2, 1967 , that (I) (we) last saw the deceased alive on 11/1 1967 , and that death occurred at 7:30 A.M. from causes and on the date stated above							
22a. SIGNATURE Robert L. Krichmar				22b. DATE SIGNED NOV 2 1967		22c. PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR M.D.	
22d. ADDRESS 7733 ALASKA AVENUE NW WASHINGTON D.C. 20012							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/6/67		23c. NAME OF CEMETERY OR CREMATORY Onawa City Cem. Onawa Iowa		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR W W Chambers Co Inc Washington DC				25a. REC'D BY REGISTRAR NOV 6 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



15537

CERTIFICATE OF DEATH

15535

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAIRLAND NURSING HOME		d. STREET ADDRESS 101 WEBSTER ST. N.E.	
3. NAME OF DECEASED (Type or print) First CLARA Middle CLAYMAN Last CLAYMAN		4. DATE OF DEATH Month 11 Day 3 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-1909
9. AGE (in years last birthday) 58		10. IF UNDER 1 YEAR Months 11 Days 3 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HYMAN BRODSKY		14. MOTHER'S MAIDEN NAME GILDA BRED	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO UNKNOWN	
17. INFORMANT MRS. SONIA FISHERMAN		Address 5115 CATHY AVE WASH. D.C.	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 DUE TO (c) 4201		INTERVAL BETWEEN ONSET AND DEATH ACUTE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis - Severe		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 1, 1967 to 2 November 1967 that (I) (we) last saw the deceased alive on 3 November 1967 , and that death occurred at 6:55 AM , from causes and on the date stated above.			
22a. SIGNATURE Jack Crowell		22b. DATE SIGNED 3 November '67	
22c. PHYSICIAN'S NAME (Type) JACK CROWELL		22d. ADDRESS 2025 EYE ST., N.W. Washington DC	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11/5/67	23c. NAME OF CEMETERY OR CREMATORY ADAMS ISRAEL CEM.	23d. LOCATION (City or town) (County) (State) WASH. D.C.
24. FUNERAL DIRECTOR Charles Jones		25a. REC'D BY REGISTRAR DATE NOV 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			



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CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 1 month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 15415 Rowland Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF (Type or print) Bessie Millicent Clements		4. DATE OF DEATH Month 11 Day 26 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/28/1895 9 AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11 BIRTHPLACE (County & State, or foreign country) Washington, DC
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Eugene Douglas Cabel	
14. MOTHER'S MAIDEN NAME Mary E. Mead		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 220-44-6712		17. INFORMANT Stanley J. Clements Address 15415 Rowland Lane Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute cardiac arrest DUE TO (b) metastatic ovarian adenocarcinoma DUE TO (c) Intestate ovarian adenocarcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 10 minutes over 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from April , 1967, to Nov. 26 , 1967, that (I) (we) last saw the deceased alive on Nov. 24 , 1967, and that death occurred at 4:45 PM , from causes and on the date stated above			
22a. SIGNATURE W H Clements		22b. DATE SIGNED Nov. 26, 1967	
22c. PHYSICIAN'S NAME (Type) William Clements, M.D.		22d. ADDRESS 6001 35th Ave., Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24a. FUNERAL DIRECTOR C. Glen Carter		24b. REGISTRAR'S SIGNATURE Charles Judge	
24c. ADDRESS 8434 Georgia Avenue		25a. REC'D BY REGISTRAR DEC 1 1967	
24d. ADDRESS Warner E. Humphrey, Inc. Silver Spring, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

15539

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spethersburg</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>15708 Ancient Oak Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Conrad Clever</u>		4. DATE OF DEATH <u>11 12 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/20/1890</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W.H. CLEVER</u>		14. MOTHER'S MAIDEN NAME <u>MOLLIE WESTAFER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>CORA A. CLEVER - SISTER - SAME</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lymphoblastic Lymphosarcoma</u>		19. WAS A TOLPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>67</u> , to <u>11/12</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/12</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Pollen</u>		22b. DATE SIGNED <u>11/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>		22d. ADDRESS <u>1040 CONNECTICUT AVE, KENNESWORTH, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		23d. LOCATION (City or town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>NOV 16 1967</u>	
ADDRESS <u>3004 EOTNE</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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VR A15 (4)
25M 1/67

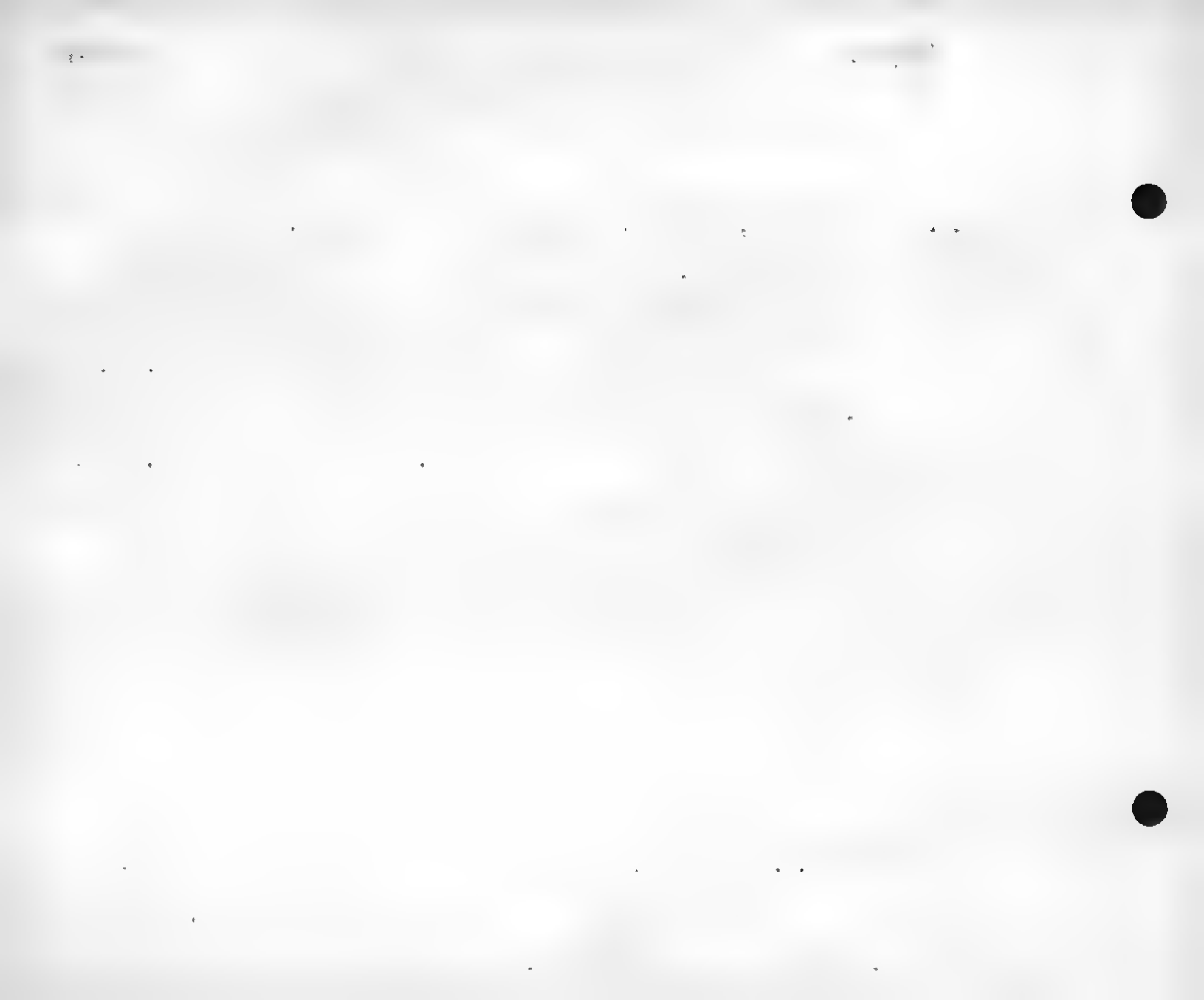
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15540

15538

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Virginia b. COUNTY Springfield			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Springfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 7200 Dormont St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lindsey H. COE				4. DATE OF DEATH Month Day Year November 25 19 67			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 SEP 1958		9. AGE (In years last birthday) 9 Yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Honolulu, Hawaii		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George B. COE				14. MOTHER'S MAIDEN NAME Virginia HARRIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO NA		17. INFORMANT George B. COE Address Springfield 7200 Dormont St., VA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEUKEMIA 2047 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH TWO YEARS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 NOV , 1967, to 25 NOV , 1967, that (I) (we) last saw the deceased alive on 25 NOV , 1967, and that death occurred at 8:45 AM , from causes and on the date stated above							
22a. SIGNATURE <i>G.P. Swartz</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 25 NOV 1967	
22c. PHYSICIAN'S NAME (Type) Lt G.P. SWARTZ, MC, USN				22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 11/26/67		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) ATHENS, TENN.	
24. FUNERAL DIRECTOR Robert E. Wilhelm				ADDRESS 4308 Suitland Rd. WDC		25a. REC'D BY REGISTRAR NOV 30 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15541

Item #2b,c & d Fill

CERTIFICATE OF DEATH

15539

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if instit on Residence before admittin) a STATE Maryland b COUNTY Montgomery Wash			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c LENGTH OF STAY IN 1b 14 hrs.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md. Hagerstown			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital				d STREET ADDRESS Belmont Nursing Home 17220 N. Hampshire Ave. 438 N. Jonathan		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Adolphus Middle Elmore Last Coffee				4 DATE OF DEATH Month Nov. Day 2 Year 67			
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-31-80		9 AGE (In years, last birthday) 87 yrs	IF UNDER 1 YEAR Months Days Hours Min 	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) S.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME UNKN				14 MOTHER'S MAIDEN NAME UNKN			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT Address Montgomery General Hospital Olney, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4300 IMMEDIATE CAUSE (a) Bronchopneumonia, L.L. b.i.c. DUE TO (b) Cachexia DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH days mos. years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus, urethral stricture & abscess							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 , that (I) (we) last saw the deceased alive on 11-2-67 , and that death occurred at 3:50 pm , from causes and on the date stated above.							
22a. SIGNATURE John R. Spencer				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11-2-67	
22c. PHYSICIAN'S NAME (Type) Dr. John R. Spencer				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/4/67		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.		23d. LOCATION (City or Town) (County) (State) Rockville Montg. Md.	
24. FUNERAL DIRECTOR Robert L. Shouder				25a. REC'D BY REGISTRAR NOV 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15548

15540

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN TB 1 yr. 4 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SYLVAN MANOR HEALTH CARE CENTER		e. STREET ADDRESS 6512 QUEENS CHAPEL ROAD	
3. NAME OF DECEASED (Type or print) ZELMA First Middle Last COHEN		4. DATE OF DEATH Nov. 12 1967 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 18, 1883 9. AGE (In years last birthday) 84 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) LUTHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHAIM ABRAHAM ROSENTHAL		14. MOTHER'S MAIDEN NAME RENA ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO	
17. INFORMANT MRS. ARTHUR WEYMAN		Address 6512 QUEENS CHAPEL ROAD, HYATTSVILLE, MARYLAND	
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) 471X DUE TO (c) CHRONIC BRAIN SYNDROME		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-14-1967 , to 11-12-1967 that (I) (we) last saw the deceased alive on 11-9-1967 , and that death occurred at 12:05 PM , from causes and on the date stated above			
22a. SIGNATURE Samuel A. Hillman MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-12-67	
22c. PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN		22d. ADDRESS 8829 FLOWER AVE SILVER SPRING, MD 20901	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-13-67	23c. NAME OF CEMETERY OR CREMATORY HERRING HILL (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Ad. Lewinson Bros.		25a. REC'D BY REGISTRAR 6010 REISTERSTOWN ROAD DATE NOV 15 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



20

MEDICAL CERTIFICATION

15541

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home		d. STREET ADDRESS 7800 Fulbright Ct.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First E.		Month 11	
Middle Warren		Day 14	
Last Colison		Year 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-09
9. AGE (in years last birthday) 58 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10b. KIND OF BUSINESS OR INDUSTRY Dept., Store	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George S. Colison		14. MOTHER'S MAIDEN NAME Eva Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-01-4857	
17. INFORMANT Lois Colison (wife)		Address 7800 Fulbright Ct., M.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 1930 Brain tumor - astrocytoma IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September, 1967 , to Nov. 14, 1967 , that (I) (we) last saw the deceased alive on Nov. 12, 1967 , and that death occurred at 12:25 AM from the causes and on the date stated above.			
22a. SIGNATURE Karl F. Wieneke, M.D.		22b. DATE SIGNED 11/14/67	
22c. PHYSICIAN'S NAME (Type) Karl F. Wieneke, M. D.		22d. ADDRESS Georgetown University Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-16-1967	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Jas. Gawler's Sons, Inc. Wash. D.C.		25. REC'D BY REGISTRAR NOV 17 1967	
25a. REGISTRAR'S SIGNATURE J. M. Judge		25b. REGISTRAR'S SIGNATURE J. M. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15544

15542

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY PRINCE GEOR.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b —	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. RAINIER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSP.		d. STREET ADDRESS 3200 CHILLUM ROAD	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOSEPH Middle A. Last COLLIERE		4. DATE OF DEATH Month 11 Day 26 Year 19 67	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/03
9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY R.R. INSPECTOR	11. BIRTH PLACE (County & State, or foreign country) WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME NOT KNOWN	
14. MOTHER'S MAIDEN NAME NOT KNOWN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II	
16. SOCIAL SECURITY NO 918-14-9908		17. INFORMANT Address MRS PHILOMENA COLLIERE - SAME #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma Lung + Bone 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 65 , to Nov , 19 67 , that (I) (we) last saw the deceased alive on Nov 25 , 19 67 , and that death occurred at 12 Noon , from causes and on the date stated above.			
22a. SIGNATURE Bernard A. Fitzgerald		22b. DATE SIGNED 11-26-67	
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22d. ADDRESS 217 UNIV. BLVD E, SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/29/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D. C.
24. FUNERAL DIRECTOR J. Wm. Lees Sons, 300 4th St. NE, Wash. DC		25a. RECD BY REGISTRAR NOV 30 1967	25b. REGISTRAR'S SIGNATURE [Signature]

3
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15543

15543

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN ID 26 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 619 University Blvd. East				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 619 University Blvd. East e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BEATRICE O. COLVIN			4. DATE OF DEATH Nov. 30, 1967				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1909		9. AGE (In years last birthday) 58 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME Charles W. Burton			14. MOTHER'S MAIDEN NAME Sarah E. Burton Smith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 		17. INFORMANT Husband Stuart E. Colvin Address Same as Item 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous (b) 505 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Carcinoma, colon, primary PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 4 mos. 6 mos.		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			
20f. (City or town) 		20g. (County) 		20h. (State) 			
21. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1967, to Nov. 30, 1967, that (I) (we) last saw the deceased alive on Oct. 28, 1967, and that death occurred at 1:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE A.W. Smith					22b. DATE SIGNED 11-30-67		
22c. PHYSICIAN'S NAME (Type) A.W. SMITH					22d. ADDRESS 13018 GEORGIA AVE WHEATON, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-2-67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			
23d. LOCATION (City, town or county) (State) Prince George County, Md.		24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					
25a. REC'D BY REGISTRAR DEC 4 1967					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

11. 11. 11.

12. 12. 12.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15545

15544

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) POTOMAC VALLEY NURS. HOME		d. STREET ADDRESS 5060 Bradley Boulevard	
3 NAME OF DECEASED (Type or print) JOHN A. CONAHAN		4 DATE OF DEATH Month 11 Day 14 Year 1967	
5 SEX m	6 COLOR OR RACE w	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-21-73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		11. BIRTHPLACE (County, State, or foreign country) STOCKTON, PA	
13 FATHER'S NAME Daniel Conahan		14 MOTHER'S MAIDEN NAME Lovena Siklekler	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16 SOCIAL SECURITY NO 577-03-99974	
17 INFORMANT Joseph Connor		Address 5100 Dorset Ave. Chevy Chase, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL ANOXIA- RESPIRATORY ARREST 15 MINS. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHO PNEUMONIA DUE TO (c) CONGESTIVE HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 5 DAYS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PLEURAL EFFUSION; ARTERIOSCLEROSIS		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF DEATH Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from JULY , 1966, to NOV. 14 , 1967, that (I) was saw the deceased alive on Nov. 13 , 1967, and that death occurred at 12:55AM , from causes on and on the date stated above.			
22a SIGNATURE Joseph I. Connor		22b. DATE SIGNED NOV. 14, 1967	
22c. PHYSICIAN'S NAME (Type) JOSEPH I. CONNOR		22d ADDRESS 9420 Old Georgetown Rd. Bethesda, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 11-17-67	23c NAME OF CEMETERY OR CREMATORY Mt. Oliver Cemetery	23d LOCATION (City or Town) (County) (State) Washington, D. C.
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a REC'D BY REGISTRAR DATE NOV 17 1967	25b REGISTRAR'S SIGNATURE Charles J. Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
15547		CERTIFICATE OF DEATH	
15545			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>910 Copley Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin Robert Conger</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 28, 1907</u>
9. AGE (in years lost birthday) <u>59</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Bruce Conger</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Marie Day</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Mother - as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Plumotoxicity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Plumotoxicity</u> DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/28</u> , 19 <u>67</u> , to <u>11/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> AM, from causes and on the date stated above			
22a. SIGNATURE <u>Charles Judge</u>		22b. DATE SIGNED <u>11/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles Judge</u>		22d. ADDRESS <u>800 42215 St S S 7 14</u>	
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>DEC 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15542

CERTIFICATE OF DEATH

15546

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>910 Copley Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Ruth</u> Last <u>Conger</u>		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY —		12. CITIZEN OF WHAT COUNTRY? —	
13. FATHER'S NAME <u>David Bruce Conger</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Marie Day</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT <u>Father (chart) as above.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>116X</u> DUE TO <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4:25 PM, 11/28/67</u> to <u>11:28 PM, 11/28/67</u> , that (I) (we) last saw the deceased alive on <u>8 PM 11/28, 1967</u> , and that death occurred at <u>11:28 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard J. Holliver</u>		22b. DATE SIGNED <u>11/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard J. Holliver</u>		22d. ADDRESS <u>Holy Cross Hospt-Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>DEC 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Alvinas Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



15549

CERTIFICATE OF DEATH

15547

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beallsville</u>		c. LENGTH OF STAY in 1b <u>yes</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>GEORGE FULTON COOLEY</u>		4 DATE OF DEATH <u>NOVEMBER 15 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 19 1980</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Own Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zachariah Cooley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. George Bodmer</u> Address <u>Beallsville MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY 4221 IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u> </u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year. Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1950</u> to <u>NOV 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 14 1967</u> , and that death occurred at <u>1 P. M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John G. Lawrence</u> M.D.		22b. DATE SIGNED <u>11/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monacacy</u>	23d. LOCATION (City or Town) (County) (State) <u>Beallsville Montg. Md</u>
24. FUNERAL DIRECTOR <u>Constance C. Hilton</u> ADDRESS <u>Barnesville Md</u>		25a. REC'D BY REG. STR. DATE <u>NOV 22 1967</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. REGISTRAR'S NAME <u> </u>	

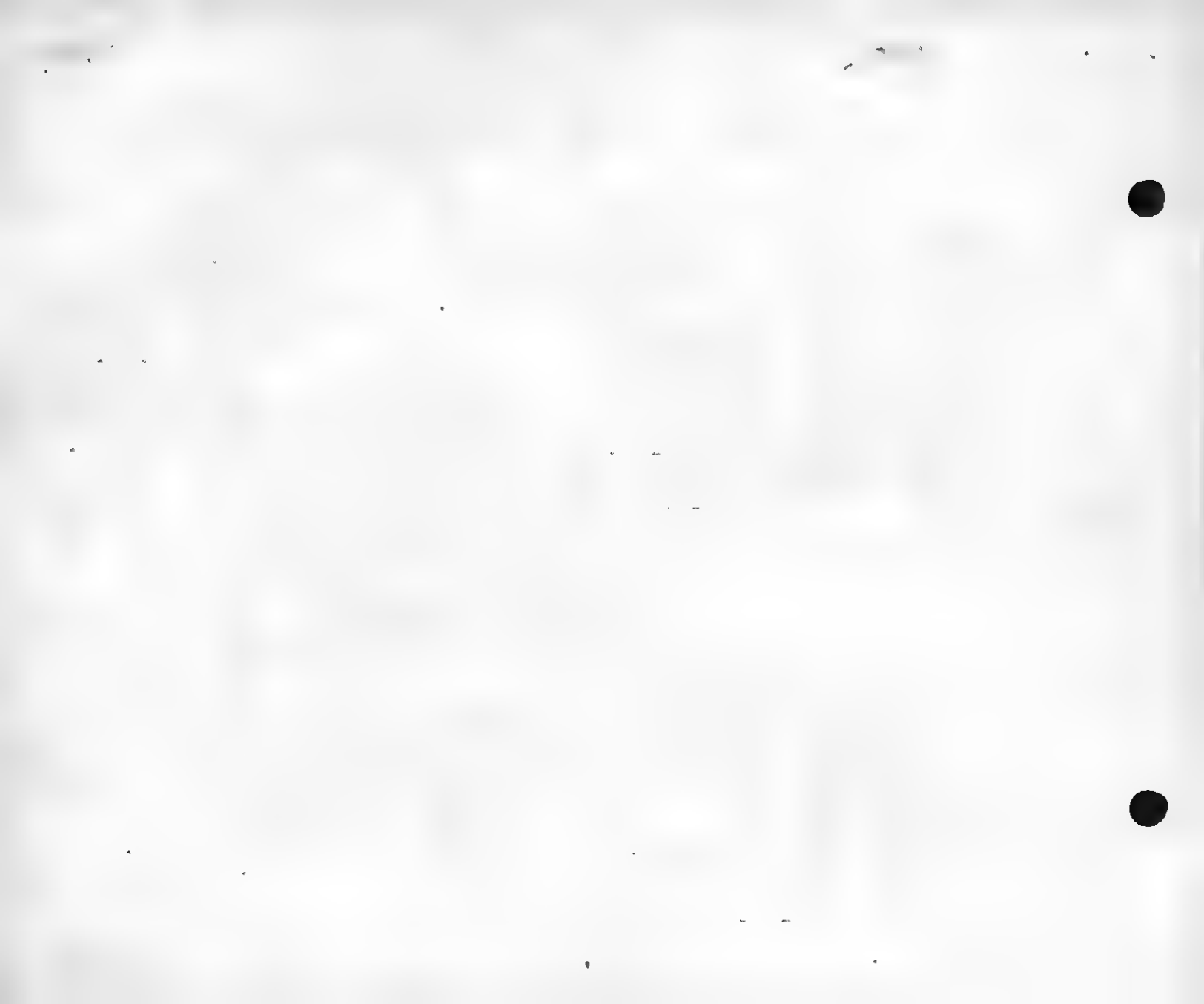
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15550 CERTIFICATE OF DEATH 15548									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 12 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4242 East-West Highway					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4242 East-West Highway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MIDDLE Last ELSPETH BROOKS MONTGOMERY COOPER					4. DATE OF DEATH Month Day Year Nov. 26, 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1914		9. AGE (in years last birthday) 53 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) International Consultant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Warren Montgomery					14. MOTHER'S MAIDEN NAME Florence Cary				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-46-2167		17. INFORMANT Husband Address Same as Item 2.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL AZOTEMIA DUE TO CHRONIC GLOMERULONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 40 YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JAN. 1, 1957 to NOV. 26, 1967 , that (I) (we) last saw the deceased alive on NOV. 25, 1967 , and that death occurred at 5:00 M, from the causes and on the date stated above.									
22a. SIGNATURE Robert G. Angle					22b. DATE SIGNED NOV. 26, 1967				
22c. PHYSICIAN'S NAME (Type) ROBERT G. ANGLE					22d. ADDRESS 5009 Del Ray Ave. Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 11-27-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION (City, town or county) (State) Suitland, Maryland		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR DEC 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



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Cooper, Mrs. Nellie

VR A15 (4)
25M 1/67

Item 18 Film 395 12-1-67		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
15551		15549	
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charleston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET <u>4</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Nellie</u> First <u>it</u> Middle <u>Cooper</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/86</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u>	11. IF UNDER 24 HRS Hours <u>1</u> Mins <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEACHER</u>	11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lemuel Rogers</u>	
14. MOTHER'S MAIDEN NAME <u>Effie Gillespie</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>233-72-3243</u>		17. INFORMANT Address <u>Ruth Bsharah-Charleston, West Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac decompensation (arteriosclerotic heart disease)</u> DUE TO <u>1500</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Bilateral lobular pneumonia</u> DUE TO (c) <u>Lytic lesions of skull, petrous part of temporal bone</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoporosis, severe</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>November 18, 1967</u> , to <u>November 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>November 20, 1967</u> , and that death occurred at <u>8 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D.		22b. DATE SIGNED <u>November 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr.</u>		22d. ADDRESS <u>9301 Glesville Rd, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>11/22/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Memorial Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>London, West Va</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>2901 14th St. N.W. Washington, D.C.</u>		DATE <u>NOV 24 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

15552 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15550

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
c. LENGTH OF STAY IN 1b 30 days		d. STREET ADDRESS 7027 Strathmore Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) EDITH B. COWELL First Middle Last		4 DATE OF DEATH Nov. 1, 1967 Month Day Year	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 22, 1888 78 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Edward Baird		14 MOTHER'S MAIDEN NAME Jane Mitchell	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO.	
17 INFORMANT Son Baird E. Cowell		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) Generalized Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/30, 1967 , to 10-31-1967 , that (I) (we) last saw the deceased alive on 10/31, 1967 , and that death occurred at 3:42 P.M. from causes and on the date stated above			
22a SIGNATURE W. T. JOYCE		22b DATE SIGNED 11-1-67	
22c PHYSICIAN'S NAME (Type) W. T. JOYCE		22d ADDRESS 4977 Battery Lane Bethesda, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11-3-67	23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a REC'D BY REGISTRAR DATE NOV 3 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15553

CERTIFICATE OF DEATH

15551

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bensington</u>		c. LENGTH OF STAY IN 1b <u>6 mos 25 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		e. STREET ADDRESS <u>2333 Kyland Pl. S.E.</u>	
3 NAME OF DECEASED (Type or print) <u>Martha Lorena Cowgill</u>		4 DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/11/80</u>
9 AGE (In years last birthday) <u>86</u> yrs		10 UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11 UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Not Known</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>(Not Known) Turner</u>	
14. MOTHER'S MAIDEN NAME <u>Not Known</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arterio sclerotic cerebral vessels</u> DUE TO <u>dissection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>generalized arterio sclerosis</u> (b) <u>dissection</u> (c) <u>generalized arterio sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bleeding peptic ulcer</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>10/9, 1967</u>	20f (City or town) <u>4/10, 1967</u> (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>10/9, 1967</u> to <u>4/10, 1967</u> that (I) (we) last saw the deceased alive on <u>4/10, 1967</u> and that death occurred at <u>9 P.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u>		22b DATE SIGNED <u>11/10/67</u>	
22c PHYSICIAN'S NAME (Type) <u>H.F. Kreuzburg</u>		22d ADDRESS <u>7852 16th Ave. W. Wash. DC</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11/14/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Broad Fording Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Hagerstown Maryland</u>
24. FUNERAL DIRECTOR ADDRESS <u>J. Wm. Lees Sons, 300 4th St. NE, Wash. DC</u>		25a REC'D BY REGISTRAR <u>NOV 14 1967</u>	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15554

CERTIFICATE OF DEATH

15552

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) SILVER SPRINGS			c. LENGTH OF STAY IN 1b 1 MO	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND PARK			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNIVERSITY NURSING HOME				d. STREET ADDRESS 103 66TH ST. N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FLORA First M. Middle COX Last		4. DATE OF DEATH NOV. Month 9 Day 19 Year 67		5. SEX FEMALE		6. COLOR OR RACE CAUC.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-24-1886		9. AGE (In years last birthday) yrs 81		F UNDER 1 YEAR Months Days 1 1 IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME MAKER		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES F. BRILL				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT (SON) Address BETHESDA, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio - DUE TO Vascular Renal Disease (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/27/67 , 19 to 11/10 , 1967, that (I) (we) last saw the deceased alive on 11/10 , 1967, and that death occurred at 12:45 AM from causes and on the date stated above.							
22a. SIGNATURE William Brainin M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11/10/67	
22c. PHYSICIAN'S NAME (Type) WM BRAININ				22d. ADDRESS 6124 Central Ave Capitol Hill			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 11-12-67		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. CREMATION DIRECTOR J. WM LEE & SONS ADDRESS 300 4TH ST. N.E., WASHINGTON, D.C.				25. REC'D BY REGISTRAR DATE NOV 14 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15555

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15553

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Parks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>2 days/2 1/2 hr</u>		d. STREET ADDRESS <u>702 CHANEY Drive #202</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>JOHN Edward COYLE</u>		4 DATE OF DEATH <u>NOVEMBER 15, 1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-17-27</u>
9. AGE (In years and birthday) <u>40 yrs</u>		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John COYLE</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW2</u>		16 SOCIAL SECURITY NO <u>577-32-5487</u>	
17 INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>4201</u> <u>Verdigris F. P. in</u>			
DUE TO (b) <u>Prophylactic</u>			
DUE TO (c) <u>Arteriosclerosis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>01</u> pm <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 25, 1967</u> , to <u>November 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>November 13, 1967</u> , and that death occurred at <u>1:15</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Stuart L. Nelson</u>		22b. DATE SIGNED <u>11-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>		22d. ADDRESS <u>7600 Carroll Ave. Takoma Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>11/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem. Baltimore, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>St. H. Hine Co 2901 14th St. NW</u>		25a. REC'D BY REGISTRAR <u>11-16-67</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

15558

17184

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>16 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>				d. STREET ADDRESS <u>1704 Black Oak Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>Eva</u> Middle <u>Craft</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1898</u>	
9. AGE (In years last birthday) <u>69</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER - Retired Co. Schools</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>XXXXXXXXXX John A. Werle</u>				14. MOTHER'S MAIDEN NAME <u>Mary Eliz. XXXXXX Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>578-38-3980 A</u>		17. INFORMANT <u>Robert H. Craft Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure, H.C.V.D. & A.S.H.D</u> DUE TO (b) <u>Arteriolar nephrosclerosis</u> DUE TO (c) <u>Thrombosis of left subclavian artery</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11</u> p.m. <u>30</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1963</u> to <u>11-30, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-29, 1967</u> , and that death occurred at <u>3:30 P.M.</u> , from causes and on the date stated above							
22a. SIGNATURE <u>G. H. Sengstack M.D.</u>				22b. DATE SIGNED <u>12-1-67</u>		22c. PHYSICIAN'S NAME (Type) <u>George H. Sengstack</u>	
22d. ADDRESS <u>9241 Columbia Blvd. Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 4, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>John S. Thomas & Son, Inc. 8434 Georgia Avenue</u>				25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>O'Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15557

CERTIFICATE OF DEATH

15554

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN IT 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		d. STREET ADDRESS 3533 Porter St., N.W.	
3 NAME OF DECEASED (Type or print) First WILLIAM Middle RAYMOND Last CRAMPTON		4 DATE OF DEATH Month NOVEMBER Day 10 Year 19 67	
5 SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 28 1891
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect'y		10b. KIND OF BUSINESS OR INDUSTRY Randolph and West	
11. BIRTHPLACE (County & State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wm. Crampton		14. MOTHER'S MAIDEN NAME Mary West	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 579-01-1295	
17. INFORMANT Wm. G. Crampton, 11122 Stephalee Lane		18. Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Emphysema DUE TO (c) Far Advanced Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 3 years 5 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/18 , 19 62 , to 11/10 , 19 67 , that (I) (we) last saw the deceased alive on 11/8 , 19 67 , and that death occurred at 8:45 A.M., from causes and on the date stated above.			
22a. SIGNATURE Frank Y. Jaggers Jr		22b. DATE SIGNED 11/10/67	
22c. PHYSICIAN'S NAME (Type) FRANK Y JAGGERS JR		22d. ADDRESS 5707 WISCONSIN AVE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 13, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Prince Geo. Co., Md.	
24. FUNERAL DIRECTOR Jos Gawler's Sons 5130 Wisconsin Av., NW.		25a. REC'D BY REGISTRAR NOV 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



15552

CERTIFICATE OF DEATH

15553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN 1b 3 yrs. 11 mos.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Althea Woodland Nursing Home		e STREET ADDRESS 5233 Partridge Lane	
3 NAME OF DECEASED (Type or print) MAUDE HAWK CREIGHTON		4 DATE OF DEATH Month Nov. Day 15 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 31, 1880
9 AGE (in years last birthday) yrs 87		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Easton, Penna.		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Forman Hawk		14 MOTHER'S MAIDEN NAME Mary Jane Morris	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 579-60-4473	
17 INFORMANT Son		Address Same as Item 2.	
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 4330 IMMEDIATE CAUSE (a) DUE TO Respiratory Failure		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) DUE TO Cardiac Arrest	
(c) DUE TO Heart Block		2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Advanced Arteriosclerosis			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 19 50 , to 11/15 19 67 , that (I) (we) last saw the deceased alive on 10/15 19 67 , and that death occurred at 6:45 P.M., from causes and on the date stated above.			
22a SIGNATURE Frank G. Jaggers Jr		22b. DATE SIGNED 11-16-67	
22c PHYSICIAN'S NAME (Type) FRANK JAGGERS JR		22d ADDRESS 5707 Wisconsin Ave. Bethesda, Maryland	
23a BURIAL CREMATION, REMOVAL (Specify) Cremation		23b DATE THEREOF 11-18-67	
23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d LOCATION (City or Town) (County) (State) Suitland, Maryland	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR NOV 17 1967	
		25b REGISTRAR'S SIGNATURE <i>W. L. Jones</i>	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transmittal permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20a-20f

film #395

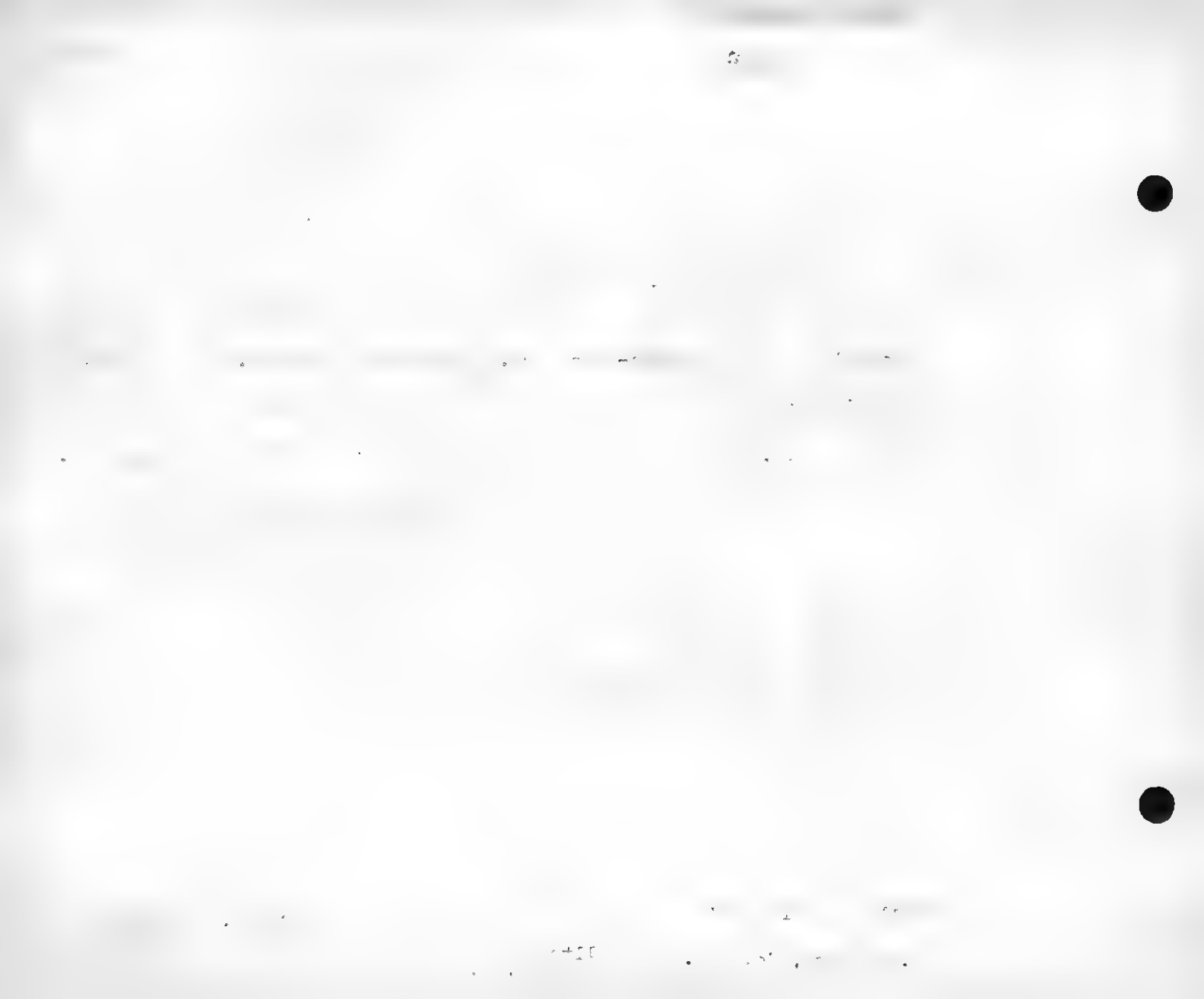
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15559 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15556

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if different from Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. STREET ADDRESS 11477 Columbia Pike Bldg	
3 NAME OF DECEASED (Type or print) Crosby, Wayne Richard		4 DATE OF DEATH Month 10 , Day Nov , Year 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/24/40
9 AGE (In years, months, days, hours, minutes) 27 yrs		10 IF UNDER 1 YEAR <input type="checkbox"/> FINDER 24 HRS <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b KIND OF BUSINESS OR INDUSTRY Bunker-Rame Corp.	
11 BIRTHPLACE (State or foreign country) Smithville Plats, N.Y.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Lewis Crosby		14 MOTHER'S MAIDEN NAME Beatrice Armentrout	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes U.S.A.F.		16 SOCIAL SECURITY NO 061-32-1723	
17 INFORMANT Beatrice Crosby (Mother) Greene, N.Y.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 823.4 IMMEDIATE CAUSE (a) Multiple Extreme Injuries DUE TO (b) including fractured skull DUE TO (c) incurred in auto accident.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Deceased lost control of Auto hitting bridge support	
20c TIME OF INJURY Month, Day, Year 10:35 p.m. 11 16 67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f (City or town) (County) (State) Silver Spring Mont Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL Burial		23b DATE THEREOF 11/20/67	
23c NAME OF CEMETERY OR CREMATORY Sylvan Lawn		23d LOCATION (City) (Town) (County) (State) Greene, New York	
24 FUNERAL DIRECTOR W.W. Chambers, Co. Inc.		25a REC'D BY REGISTRAR NOV 20 1967	
25b REGISTRAR'S SIGNATURE Charles Judge		25c REGISTRAR'S SIGNATURE	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (B)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Seaboard</i>		e. STREET ADDRESS <i>7807 Starke Rd</i>	
3. NAME OF DECEASED (Type or print) <i>John Paul Crowley</i>		4. DATE OF DEATH <i>November 29 1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 26-1917</i>
9. AGE (In years last birthday) <i>50</i>		10. IF UNDER 1 YEAR: Months <i>29</i> Days <i>19</i> Hours <i>67</i> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Secretary</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Supermarket Corp.</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington - D.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>John G. Crowley</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Casey</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes 1941-1945</i>		16. SOCIAL SECURITY NO. <i>578-09-4237</i>	
17. INFORMANT <i>Mrs. Crowley</i>		Address <i>above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Massive intracerebral hemorrhage, left, spontaneous</i>			
443X DUE TO <i>Hypertensive cardio-vascular disease</i>			
(b) <i>years</i>			
DUE TO (c) <i>years</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cirrhosis of liver, Laennec's type Wt 3000 grams</i>			
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		22. DATE SIGNED <i>11/29/67</i>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		Address (Street, City, town, or county) <i>Bethesda, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-4-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>DEC 7 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15561

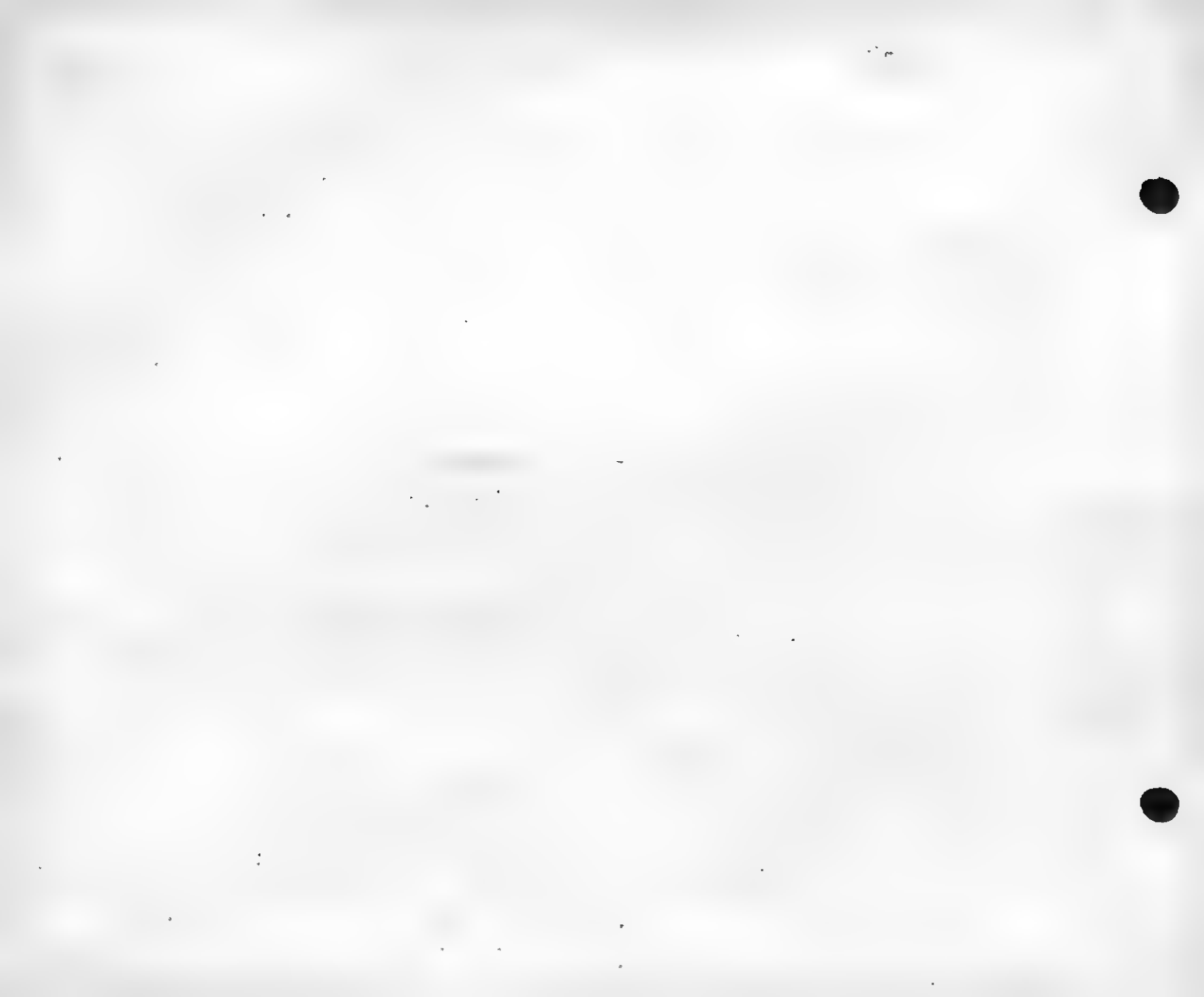
CERTIFICATE OF DEATH

15557

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b Washington, D.C. d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Carroll Hall Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 4016 14th St. N.W. Kensington, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROSE Middle M. Last Cullen				4. DATE OF DEATH Month Nov. Day 21 Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1882	9. AGE (In years last birthday) 85 yrs	10. IF UNDER 1 YEAR Months 21 Days 19 Hours 67	11. IF UNDER 24 HRS Months 21 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ferdinand E. Burch				14. MOTHER'S MAIDEN NAME Sophronia Guy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No - - -		16. SOCIAL SECURITY NO. 219-54-9722		17. INFORMANT Anna King Handwerk-8302 Woodhaven Blvd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) 771X DUE TO (c) Chronic Pulmonary Fibrosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pulmonary Fibrosis Generalized						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) arteriosclerosis		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20d. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20e. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-17-67 , to 11-21-67 , that (I) (we) last saw the deceased alive on 11-21-67 , and that death occurred at 5P M, from causes and on the date stated above.							
22a. SIGNATURE C.P. Ryland		22b. DATE SIGNED 11-21-67		22c. PHYSICIAN'S NAME (Type) C.P. RYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-25-1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wash. D.C.				25a. REC'D BY REGISTRAR NOV 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. These should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

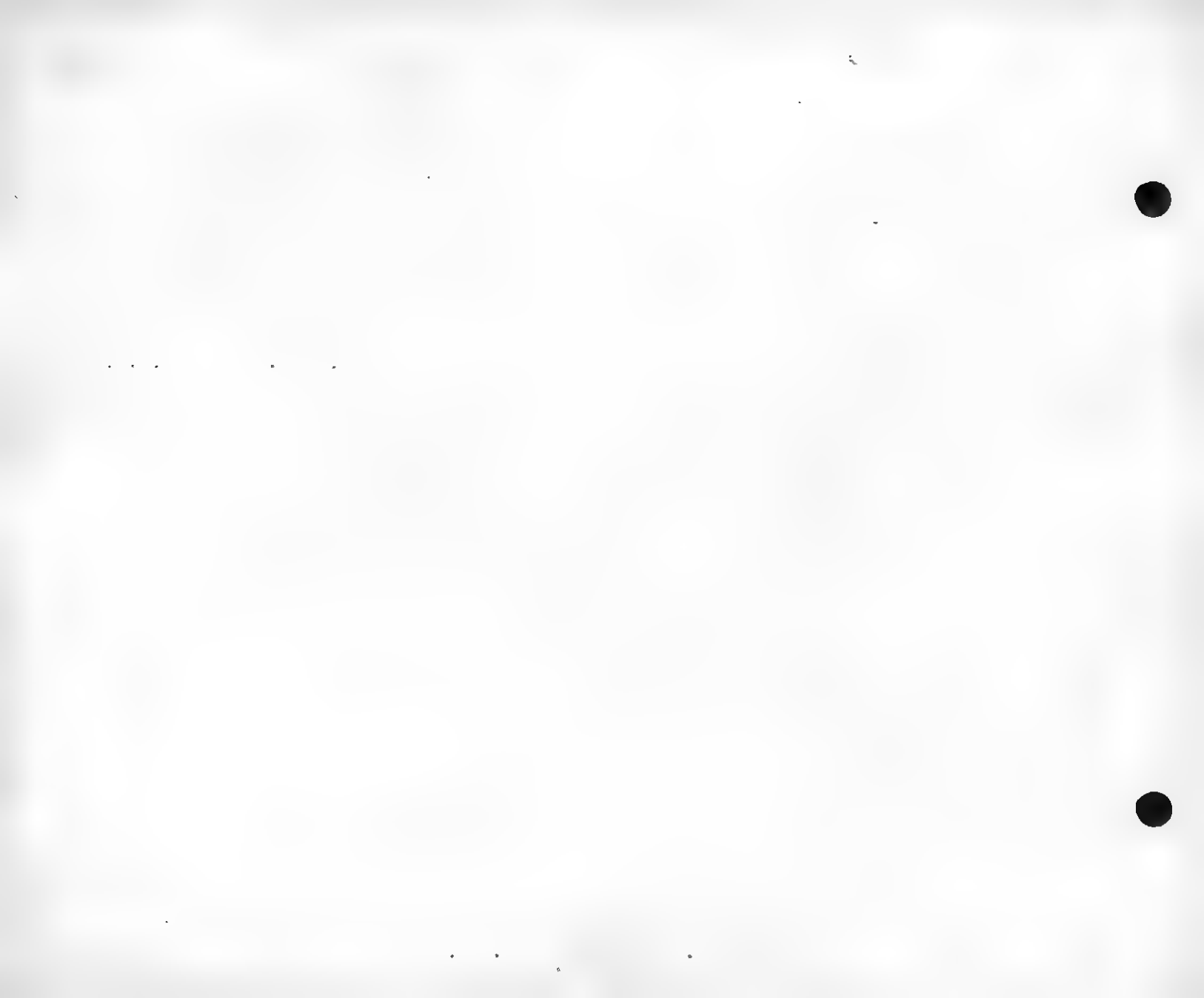
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15562

CERTIFICATE OF DEATH

15558

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c LENGTH OF STAY IN it 15 d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda-Silver Spring Nursing Home		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d STREET ADDRESS 3722 Manor Road • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) NINA First Maynard Middle Curtis Last 4 DATE OF DEATH Month Nov Day 21 Year 1967		5 SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 2-25-1875 9. AGE (In years last birthday) yrs. 92 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY - - - 11. BIRTHPLACE (County & State or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Hutchinson Martin 14. MOTHER'S MAIDEN NAME Nancy Jane Kinch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. - - - 17. INFORMANT Mrs. Nina Brumbaugh - See Item No. 2 Address			
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO (b) Myocarditis DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from Nov 13 , 19 66 to Nov 21 , 19 67 , that (I) (we) last saw the deceased alive on Nov 13 , 19 67 , and that death occurred at 6:55 AM, from causes and on the date stated above			
22a SIGNATURE Wm Fleet Lockett M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED 11. 21 67		22c PHYSICIAN'S NAME (Type) Wm Fleet Lockett 22d ADDRESS 5000 Pennsylvania	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11-24-1967 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery 23d. LOCATION (City or Town) (County) (State) Washington, D.C.		24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave. NW. Wash. D.C. 25a. REC'D BY REGISTRAR NOV 24 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15563

15559

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> c. LENGTH OF STAY IN b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u> <u>Jakoma Park, Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> d. STREET ADDRESS <u>7911 Greenwood Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Phoebe M. Davis</u>		4. DATE OF DEATH <u>November 25 1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 19, 1895</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>6</u>	
11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Ditzler</u>		14. MOTHER'S MAIDEN NAME <u>Frances Vernon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>YES</u>	
17. INFORMANT <u>Mrs. Dorothy Williams</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>heart failure</u> DUE TO <u>acute hepatic necrosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. <u>metastatic carcinoma</u> DUE TO (c) <u>metastatic carcinoma</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>stress ulceration stomach; carcinoma colon</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> <u>1967</u> to <u>11/25</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>11/25</u> <u>1967</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman H. Shaarson</u> M.D.		22b. DATE SIGNED <u>DEC 1 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>NORMAN H. SHAARSON MD</u>		22d. ADDRESS <u>915 - 19th St NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 28, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25. ADDRESS <u>8434 Ga. Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15566

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15560

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		a STREET ADDRESS <u>3507 Kensington Crt.</u>	
3 NAME OF DECEASED (Type or print) <u>Reuben B. Dean</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-3-84</u>
9 AGE (In years last birthday) <u>83</u> yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>unknown</u>		14 MOTHER'S MAIDEN NAME <u>unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>?</u>	
17 INFORMANT <u>Liberty Dean-3507-Kensington Ct.</u>		18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Embolus</u> DUE TO (b) <u>Bilateral Lobular Pneumonia</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Heart Disease</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>OCT. 5, 1967</u> to <u>NOV. 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 18, 1967</u> , and that death occurred at <u>12 P.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>James A. Roberts</u>		22b. DATE SIGNED <u>11/18/67</u>	
22c PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		22d ADDRESS <u>8907 GEO. AVE. SILVER SPRING, MD.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 22, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Dean Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Green County, Virginia</u>
24. FUNERAL DIRECTOR <u>James E. Pumphrey, Inc. 8434 Ga. Avenue</u>		25a REC'D BY REGISTRAR DATE <u>NOV 22 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-15-68. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/67

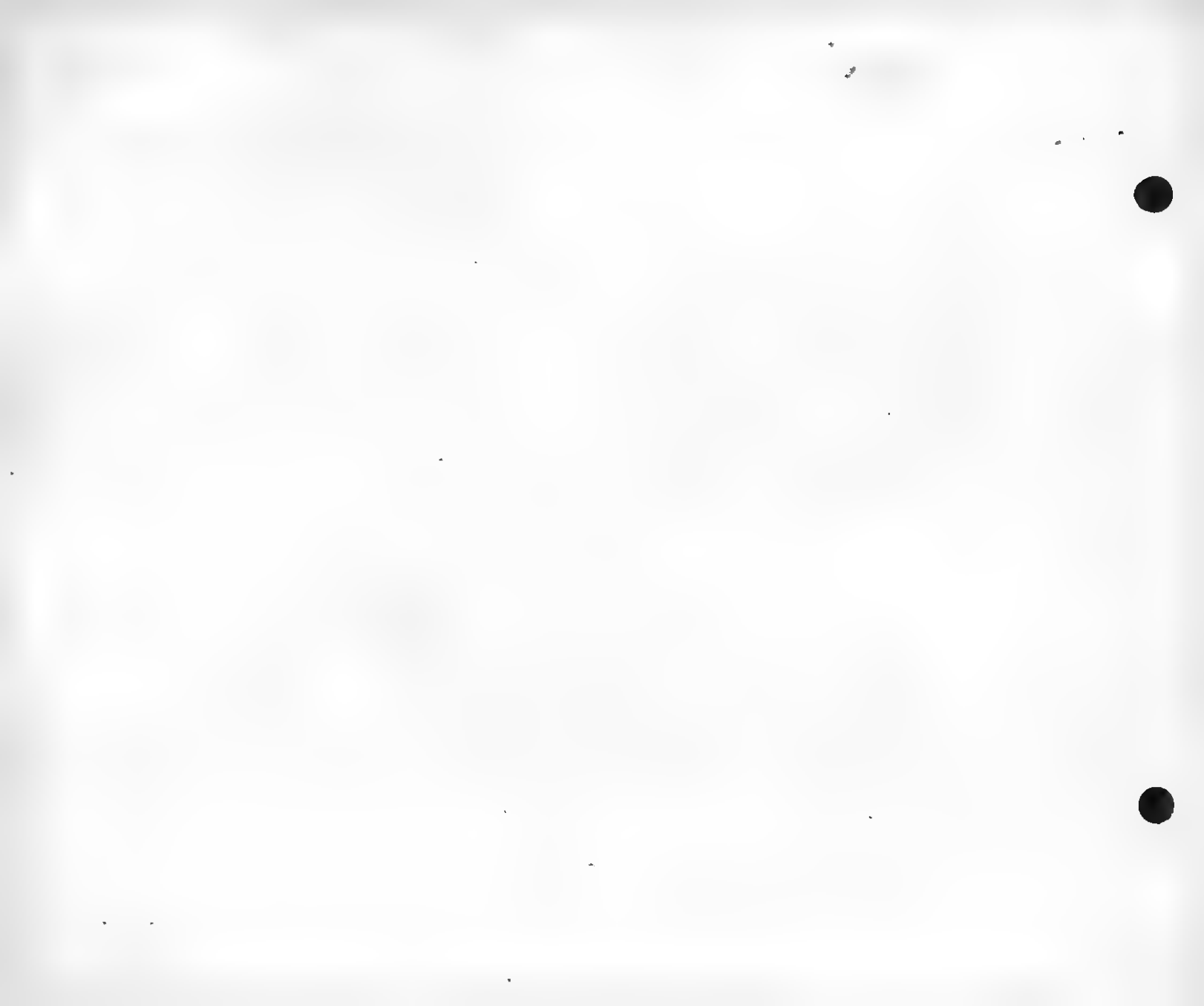
Items 18&21 Film 396
1-15-68 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15561

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN It Greenbelt	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Amy Viola Dent		4 DATE OF DEATH Month 11 Day 27 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-12-1894 73 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? US	
13 FATHER'S NAME Josiah Lindsay		14 MOTHER'S M maiden name Rosanna Hamilton	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 579-28-6735	
17 INFORMANT Mary T. Brown-803 Seeks Lane, Silver Spring, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO (b) insufficiency; DUE TO (c) Coronary artery heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z, aa, ab, ac, ad, ae, af, ag, ah, ai, aj, ak, al, am, an, ao, ap, aq, ar, as, at, au, av, aw, ax, ay, az, ba, bb, bc, bd, be, bf, bg, bh, bi, bj, bk, bl, bm, bn, bo, bp, bq, br, bs, bt, bu, bv, bw, bx, by, bz, ca, cb, cc, cd, ce, cf, cg, ch, ci, cj, ck, cl, cm, cn, co, cp, cq, cr, cs, ct, cu, cv, cw, cx, cy, cz, da, db, dc, dd, de, df, dg, dh, di, dj, dk, dl, dm, dn, do, dp, dq, dr, ds, dt, du, dv, dw, dx, dy, dz, ea, eb, ec, ed, ee, ef, eg, eh, ei, ej, ek, el, em, en, eo, ep, eq, er, es, et, eu, ev, ew, ex, ey, ez, fa, fb, fc, fd, fe, ff, fg, fh, fi, fj, fk, fl, fm, fn, fo, fp, fq, fr, fs, ft, fu, fv, fw, fx, fy, fz, ga, gb, gc, gd, ge, gf, gg, gh, gi, gj, gk, gl, gm, gn, go, gp, gq, gr, gs, gt, gu, gv, gw, gx, gy, gz, ha, hb, hc, hd, he, hf, hg, hh, hi, hj, hk, hl, hm, hn, ho, hp, hq, hr, hs, ht, hu, hv, hw, hx, hy, hz, ia, ib, ic, id, ie, if, ig, ih, ii, ij, ik, il, im, in, io, ip, iq, ir, is, it, iu, iv, iw, ix, iy, iz, ja, jb, jc, jd, je, jf, jg, jh, ji, jj, jk, jl, jm, jn, jo, jp, jq, jr, js, jt, ju, jv, jw, jx, jy, jz, ka, kb, kc, kd, ke, kf, kg, kh, ki, kj, kk, kl, km, kn, ko, kp, kq, kr, ks, kt, ku, kv, kw, kx, ky, kz, la, lb, lc, ld, le, lf, lg, lh, li, lj, lk, ll, lm, ln, lo, lp, lq, lr, ls, lt, lu, lv, lw, lx, ly, lz, ma, mb, mc, md, me, mf, mg, mh, mi, mj, mk, ml, mm, mn, mo, mp, mq, mr, ms, mt, mu, mv, mw, mx, my, mz, na, nb, nc, nd, ne, nf, ng, nh, ni, nj, nk, nl, nm, nn, no, np, nq, nr, ns, nt, nu, nv, nw, nx, ny, nz, oa, ob, oc, od, oe, of, og, oh, oi, oj, ok, ol, om, on, oo, op, oq, or, os, ot, ou, ov, ow, ox, oy, oz, pa, pb, pc, pd, pe, pf, pg, ph, pi, pj, pk, pl, pm, pn, po, pp, pq, pr, ps, pt, pu, pv, pw, px, py, pz, qa, qb, qc, qd, qe, qf, qg, qh, qi, qj, qk, ql, qm, qn, qo, qp, qq, qr, qs, qt, qu, qv, qw, qx, qy, qz, ra, rb, rc, rd, re, rf, rg, rh, ri, rj, rk, rl, rm, rn, ro, rp, rq, rr, rs, rt, ru, rv, rw, rx, ry, rz, sa, sb, sc, sd, se, sf, sg, sh, si, sj, sk, sl, sm, sn, so, sp, sq, sr, ss, st, su, sv, sw, sx, sy, sz, ta, tb, tc, td, te, tf, tg, th, ti, tj, tk, tl, tm, tn, to, tp, tq, tr, ts, tt, tu, tv, tw, tx, ty, tz, ua, ub, uc, ud, ue, uf, ug, uh, ui, uj, uk, ul, um, un, uo, up, uq, ur, us, ut, uu, uv, uw, ux, uy, uz, va, vb, vc, vd, ve, vf, vg, vh, vi, vj, vk, vl, vm, vn, vo, vp, vq, vr, vs, vt, vu, vv, vw, vx, vy, vz, wa, wb, wc, wd, we, wf, wg, wh, wi, wj, wk, wl, wm, wn, wo, wp, wq, wr, ws, wt, wu, wv, ww, wx, wy, wz, xa, xb, xc, xd, xe, xf, xg, xh, xi, xj, xk, xl, xm, xn, xo, xp, xq, xr, xs, xt, xu, xv, xw, xx, xy, xz, ya, yb, yc, yd, ye, yf, yg, yh, yi, yj, yk, yl, ym, yn, yo, yp, yq, yr, ys, yt, yu, yv, yw, yx, yy, yz, za, zb, zc, zd, ze, zf, zg, zh, zi, zj, zk, zl, zm, zn, zo, zp, zq, zr, zs, zt, zu, zv, zw, zx, zy, zz			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Keap M.D.		22. DATE SIGNED Nov. 27, 1967	
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/1/67	
23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City or Town) (County) (State) Prince George Co., Md.	
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike		25a. REC'D BY REGISTRAR DEC 1 1967	
ADDRESS Rockville, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

15566

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15562

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN TB <u>4 hrs</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>908 Bedford St</u>	
3 NAME OF DECEASED (Type or print) <u>Lena</u> First <u>B</u> Middle <u>Gertrude</u> Last		4 DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/9/1885</u> 82 yrs
9a USIA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		9b AGE (In years last birthday) <u>82</u>	
10a BIRTHPLACE (State or foreign country) <u>Bethesda, Pa</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Harvey Leasure</u>		14 MOTHER'S MAIDEN NAME <u>Virginia Hardinger</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Daughter, Edith Taylor Beth. St.</u>		Address <u>534 Plummer</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>congestive Heart Failure</u> (c) <u>Chronic Bronchitis Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>11/14/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>NOV. 17, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>ZION MEMORIAL PARK</u>	23d LOCATION (City or Town) (County) (State) <u>CUMBERLAND, MD.</u>
24 FUNERAL DIRECTOR <u>BYRON KIGHT</u>		25 RECEIVED BY REGISTRAR DATE <u>NOV 16 1967</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. These should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
15567											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Cekington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. LENGTH OF STAY IN 1b <u>3 days</u>					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cekington</u>						d. STREET ADDRESS <u>3189 So. Stafford St.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <u>Beonislawa DeWzalska</u>						4 DATE OF DEATH <u>11-30</u> 19 <u>67</u>					
5 SEX <u>F</u>		6 COLOR OR RACE <u>Gr</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>7-21-1891</u>		9 AGE (in years last birthday) <u>76</u>		10 UNDER 1 YEAR <input type="checkbox"/> 10 UNDER 24 HRS <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>				10b KIND OF BUSINESS OR INDUSTRY <u>-</u>				11 BIRTHPLACE (County & State, or foreign country) <u>Poland</u>			
13 FATHER'S NAME <u>Roman Tomoeski</u>						14. MOTHER'S MAIDEN NAME <u>-</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO <u>-</u>					
17 INFORMANT <u>George DeWzalski - same as #2</u>						Address <u>-</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>											
4341 DUE TO (b) <u>Plorodysrrolia of an Haverdigan</u>											
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Extensive infarction of atherosclerosis</u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>						20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that (I) (th's hospital) attended the deceased from <u>11-27-</u> , 19 <u>65</u> , to <u>11-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-29-</u> , 19 <u>67</u> , and that death occurred at <u>10 AM</u> , from causes and on the date stated above.											
22a SIGNATURE <u>Walter Richman M.D.</u>						ATTENDING PHYS <input checked="" type="checkbox"/> MEO DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>12-1-67</u>			
22c PHYSICIAN'S NAME (Type) <u>-</u>						22d ADDRESS <u>4740 Al Dr Prince Georges Md</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b DATE THEREOF <u>12-4-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>				23d LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR <u>H. Don. DeVol 2222 Wis. Ave N.W.</u>						ADDRESS <u>D.C.</u>		25a REC'D BY REG STRAR <u>DEC 5 1967</u>		25b REGISTRAR'S SIGNATURE <u>-</u>	

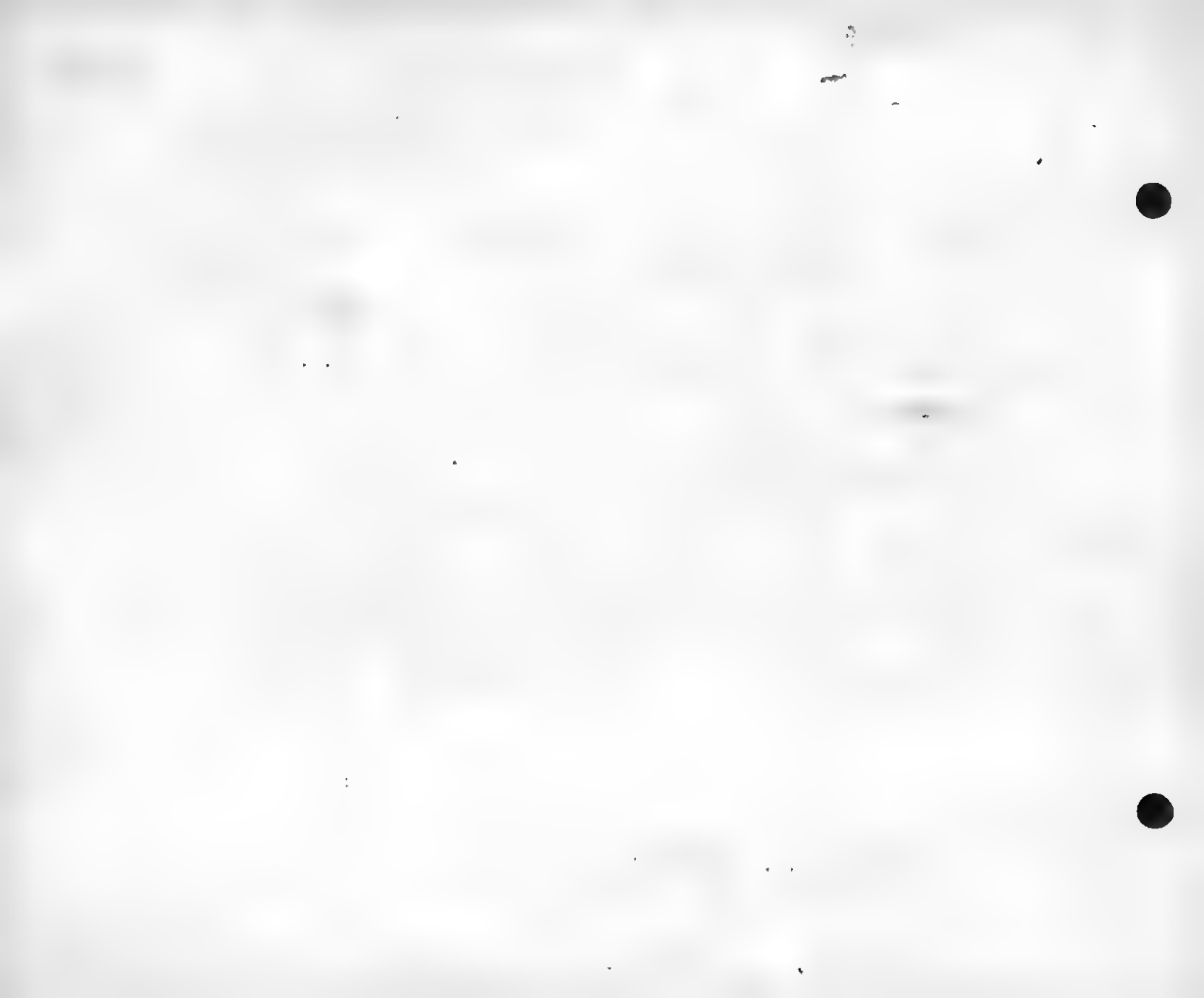
CERTIFICATE OF DEATH

15564

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL) c. LENGTH OF STAY in 1b 5 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 915 MAPLE AVE e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JOHN FRANK DONAHAE		4. DATE OF DEATH Month NOVEMBER Day 25 Year 19 67	
5 SEX MALE	6 COLOR OR RACE CAUC	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 NOVEMBER 14 53
9a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		9b AGE (In years last birthday) yrs 14	9c AGE (In years last birthday) yrs 14
10a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b KIND OF BUSINESS OR INDUSTRY Retired	11 BIRTHPLACE (County & State, or foreign country) ENGLEWOOD, N.J.
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM DONAHAE	
14. MOTHER'S MAIDEN NAME ELIZABETH MULLER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII	
16. SOCIAL SECURITY NO. 577 40 0954		17 INFORMANT Edna L. Donahae - wife - 3 re it ... " 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause most (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 20 NOV , 19 67 , to 25 NOV , 19 67 , that (I) (we) last saw the deceased alive on 25 NOV , 19 67 , and that death occurred at 1:15 AM , from causes and on the date stated above			
22a SIGNATURE C.S. Reeves		22b ADDRESS NAVAL HOSPITAL, BETHESDA, MD	
22c PHYSICIAN'S NAME (Type) LT C.S. REEVES, MC, USN		22d ADDRESS NAVAL HOSPITAL, BETHESDA, MD	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 11/28/67	23c NAME OF CEMETERY OR CREMATORY Unionville, Virginia	23d LOCATION (City or Town) (County) (State) Unionville, Virginia
24 FUNERAL DIRECTOR TYSON WHEELER,		25a REC'D BY REGISTRAR NOV 28 1967	
25b REGISTRAR'S SIGNATURE Judge		25c REGISTRAR'S SIGNATURE Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15569

15565

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a STATE <u>Maryland</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b	
d NAME OF HOSP TAL OR INSTITUTION (If not n hospital, give street address) <u>Holy Cross Hosp</u>		d STREET ADDRESS <u>1500 E.W. Highway</u>	
3 NAME OF DECEASED (Type or print) <u>Joan Marie Donaldson</u>		4 DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/7/67</u>
10a USUAL OCCUPAT ON (Give kind of work done during most of working life even if retired)		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs <u>14</u> Months <u>5</u> Days <u>0</u> Min <u>0</u>
11 BIRTHPLACE (County & State or foreign country) <u>Montgomery Co., Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Craig Donaldson</u>		14 MOTHER'S MAIDEN NAME <u>Nancy Seoller</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>-</u>	
17 INFORMANT <u>husband (via chart)</u>		Address <u>(as above)</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO <u>a. Pulmonary hyaline membrane dis</u> (b) <u>- Subarachnoid hemorrhage</u> DUE TO <u>(c) - Intraventricular hemorrhage</u>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/7/67</u> , 19 <u>67</u> , to <u>11/7/67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>11/7/67</u> 19 <u>67</u> , and that death occurred at <u>8:00 PM</u> , from causes and on the date stated above			
22a SIGNATORY <u>Lawrence H. Drimbeg</u> M.D.		22b DATE SIGNED <u>11/8/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Attending Physician</u>		22d ADDRESS <u>111 University Blvd., Silver Spring</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>11/7/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24 FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a REC'D BY REGISTRAR <u>NOV 13 1967</u>	
ADDRESS <u>1331 Rock Pike Rockville, Md.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

8P

7-242156



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15570

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15566

1 PLACE OF DEATH a. COUNTY <u>Mont. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Mont. Co.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c LENGTH OF STAY IN 1b <u>151</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>100 - North Street</u>		d STREET ADDRESS <u>100 N. 5th Street</u>	
3 NAME OF DECEASED (Type or print) <u>Lillian</u> <u>Hershey</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>1967</u>	
5 SEX <u>Fe.</u>	6 COLOR OR RACE <u>Colored</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 26, 1886</u>
9 AGE (In years last birthday) <u>81</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13 FATHER'S NAME <u>Unknown</u>	
14 MOTHER'S MAIDEN NAME <u>Rebecca Vail</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word or dates of service)	
16. SOCIAL SECURITY NO.		17 INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY <u>9160</u> IMMEDIATE CAUSE (a) <u>Asphyxia & Carbon Monoxide poisoning, accidental</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Stove explosion and gas suffocation</u> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Gas oven exploded when trying to light it. Caused burns & shock</u>	
20c TIME OF INJURY Month Day, Year <u>Nov. 22, 1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>Home</u>		20f (City or town) (County) (State) <u>Rockville Mont. Md.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov. 28, 1967</u>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF	
<u>BURIAL</u>		<u>Dec. 2, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
<u>Lincoln Park Cemetery</u>		<u>Rockville Mont. Md.</u>	
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR	
<u>Robert L. Snowden</u>		<u>DEC 6 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	



15571

CERTIFICATE OF DEATH

15567

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not in on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>9039 SLIGO CREEK PKWY</u>	
3. NAME OF DECEASED (Type or print) <u>BLANCHE</u> XXXXX <u>DORTMAN</u>		4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/3/11</u>
9. AGE (In years last birthday) <u>56</u> yes		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months <u>11</u> Days <u>20</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CENTERVILLE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MENDEL NICKEL</u>		14. MOTHER'S MAIDEN NAME <u>ROSE PUSHKIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>215-10-6535</u>	
17. INFORMANT <u>MR. JOSEPH S. DOREMAN</u>		Address <u>9039 SLIGO CREEK PKWY, PARKSIDE PLAZA APTS. SILVER SPRING</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>170X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>62</u> , to <u>Nov 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 20</u> 19 <u>67</u> , and that death occurred at <u>7:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11/20/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. ETC</u>		22d. ADDRESS <u>8641 Columbia Rd Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WORKMENS CIRCLE</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15572

15568

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>10-10-67 to 11-15-67</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>			d. STREET ADDRESS <u>3352 Chiswick Court Apt 3G</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Young</u> Last <u>DRAKE</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>15</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-96</u>	9. AGE (In years last birthday) <u>71</u> yrs	F UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Retired) Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>		11. BIRTHPLACE (County & State or foreign country) <u>Tecumseh, Neb</u>	
13. FATHER'S NAME <u>ELMER E. YOUNG</u>			14. MOTHER'S MAIDEN NAME <u>MOLLY CASTRO</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>11-16-27661</u>		17. INFORMANT <u>ROBERT J. DRAKE</u> Address <u>SAME AS #2A-B-C-D</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>331x</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>July</u>	20f. (City or town) (County) (State) <u>Nov 1967</u>	21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>Nov</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 5</u> , 19 <u>67</u> , and that death occurred at <u>1:34 PM</u> from causes and on the date stated above	
22a. SIGNATURE <u>Richard A. Yates MD</u>		M.O. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>11/15/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>RICHARD A. YATES</u>		22d. ADDRESS <u>OLNEY, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WYUKA CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>LINCOLN, NEBRASKA</u>		
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS INC - SILVER SPRING, MD</u>		25a. REC'D BY REGISTRAR <u>DATE NOV 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		



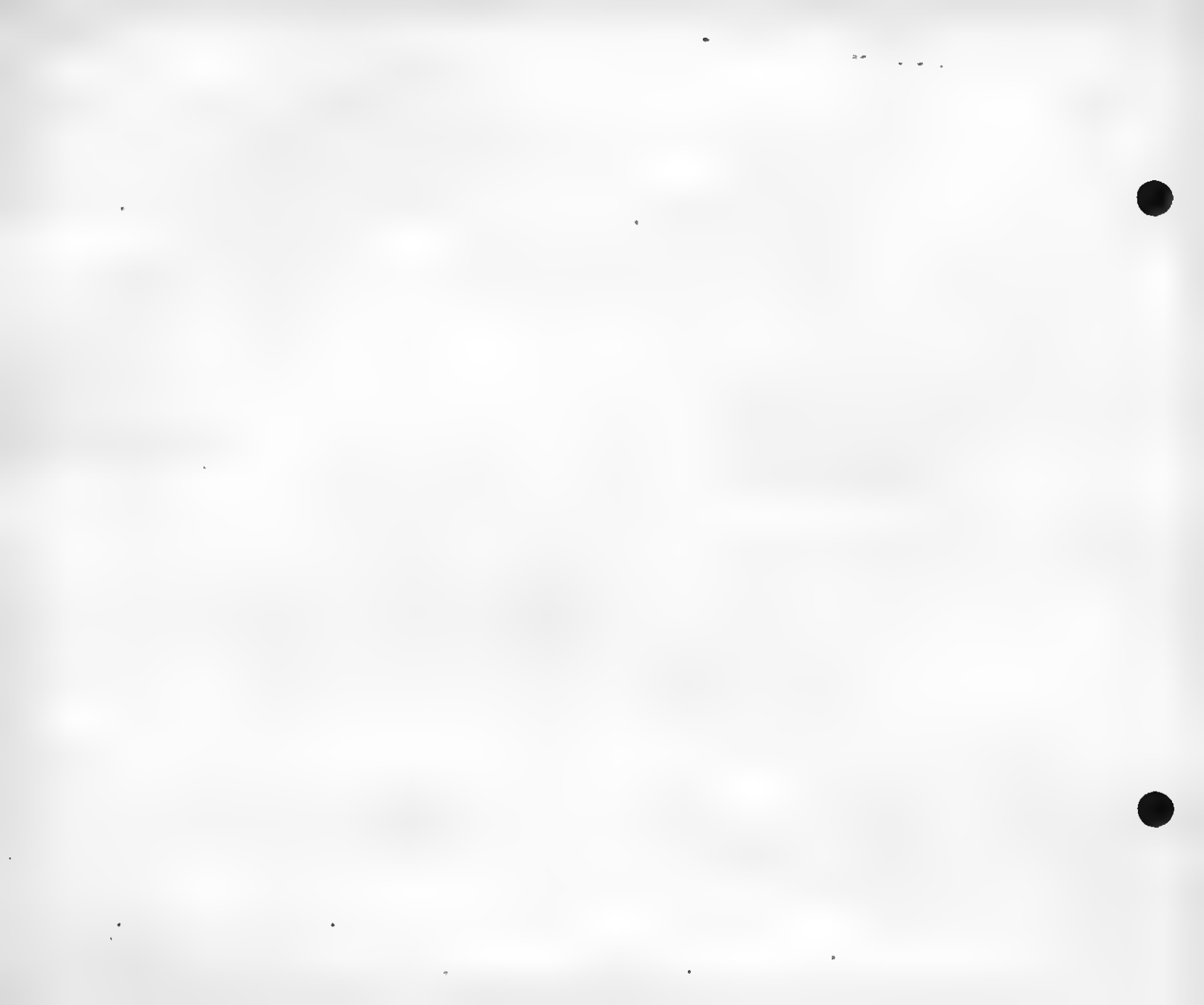
15573

15569

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15-1				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4614 West Virginia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Albert Young Lreisonstok First Middle Last				4. DATE OF DEATH November 30, 1967 Month Day Year			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	DATE OF BIRTH 8/14/94	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative officer - Navy Lt.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Jacob Lreisonstok				
14. MOTHER'S MAIDEN NAME Fannie Leah Young			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes World War I				
16. SOCIAL SECURITY NO			17. INFORMANT Richard Lreisonstok Address 706 Forest Glen Rd. Silver Spring Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 11/1, 1967 , to 11/30, 1967 , that (I) (we) last saw the deceased alive on 11/14 1967 , and that death occurred at 11 A M, from causes and on the date stated above							
22a. SIGNATURE Dr Joseph P. Kenrick		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 11/30/67				
22c. PHYSICIAN'S NAME (Type) DR JOSEPH P. KENRICK		22d. ADDRESS 6450 Wisconsin Ave, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 12/4/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore, Md.		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR The S.H. Hines Company		ADDRESS 2901 14th St. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR DEC 4 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1002. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

Items 18, 21 film #395 MARYLAND STATE DEPARTMENT OF HEALTH
12-6-67 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
25576 Item #10 Film - 12/6/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15570

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Sandy Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS Box 276	
3. NAME OF DECEASED (Type or print) William Ray Dresser		4. DATE OF DEATH Month 11 Day 26 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/05
9. AGE (In years last birthday) 62 yrs		10. FUNDING YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Dresse r		14. MOTHER'S MAIDEN NAME Janie Lanham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 578-05-0861	
17. INFORMANT Medical Records of Montg. General Hospt.		Address Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial Infarction DUE TO (b) left anterior ventricular wall; DUE TO (c) Coronary Artery Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Reap		22. DATE SIGNED Nov. 26, 1967	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-67	
23c. NAME OF CEMETERY OR CREMATORY Burtonsville		23d. LOCATION (City or Town) (County) (State) Burtonsville, Maryland	
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 29 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

15575

CERTIFICATE OF DEATH

15571

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>28 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DICKERSON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Route # 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle Last <u>Dyson</u>				4. DATE OF DEATH Month <u>11</u> - Day <u>7</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-19</u> <u>48</u>		9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Prather</u>				14. MOTHER'S MARDEN NAME <u>Bertha Prather</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Adenocarcinoma, left breast</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-11</u> , 19 <u>67</u> , to <u>11-6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-6</u> , 19 <u>67</u> , and that death occurred at <u>12:00</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Stanley M. Bralun</u>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George R. Snowden</u>				22d. ADDRESS <u>Rockville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ELIZAH Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Boolesville, Montg Md</u>	
24. FUNERAL DIRECTOR <u>George R. Snowden</u>				25a. REC'D BY REGISTRAR <u>Rockville Md</u>		25b. REGISTRAR'S SIGNATURE <u>Richard J. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

VR A15 (M)
25M 1/67

15575

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15572

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>District of Columbia</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN <u>3 days</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>		d STREET ADDRESS <u>915 Kennedy St. N.W.</u>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>Martha Washington Early</u>		4 DATE OF DEATH <u>Nov. 31 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-22-12</u> 55 yrs
9a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)		9b AGE (In years last birthday) <u>55</u> yrs	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY <u>trass</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Poston</u>		14. MOTHER'S MAIDEN NAME <u>Edith Stickles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-12-0000</u>	
17. INFORMANT <u>W.S.H. Hospital Records</u>		Address <u>Park, Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4331 Cardiac Arrhythmic & Spontaneous + High grade</u> DUE TO <u>Circ. Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>It had previous arrhythmia & went into fibrillation</u> DUE TO <u>It had previous arrhythmia & went into fibrillation</u> DUE TO <u>It had previous arrhythmia & went into fibrillation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 day</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21 I certify that (I) (th's hospital) attended the deceased from <u>11/21/67</u> to <u>11/21/67</u> , that (I) (we) last saw the deceased alive on <u>11/21/67</u> 19 <u>67</u> , and that death occurred at <u>1:30 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Chas H. Holston, M.D.</u>		22b DATE SIGNED <u>11/21/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Chas H. Holston</u>		22d ADDRESS <u>8312 Univ Blvd E. Silver Spring</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>11/25/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem</u>		23d LOCATION (City or town) (County) (State) <u>Prince George's Co. Md.</u>	
24 FUNERAL DIRECTOR <u>Heeler Funeral Home</u>		25a REC'D BY REGISTRAR <u>NOV 27 1967</u>	
25b REGISTRAR'S SIGNATURE <u>John A. Judge</u>			

15577

CERTIFICATE OF DEATH

15573

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 'b' 32 days		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Illinois b. COUNTY Glendale Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 449 Altgeld Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Lewis Donald ELLIS		4 DATE OF DEATH Month November Day 14 Year 19 67			
5 SEX Male	6 COLOR OR RACE Cauc.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 18, 1947		9 AGE (In years last birthday) 20 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Haleyville, Alabama	
13 FATHER'S NAME Benjamin Paul Ellis		14. MOTHER'S MAIDEN NAME Naomi Cummings		12. CITIZEN OF WHAT COUNTRY? USA	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Aug 64-Nov 67		16 SOCIAL SECURITY NO 336 40 5773		17 INFORMANT Mrs. Naomi Moore, 449 Altgeld Avenue	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7543 Congenital heart disease; atrial septal defect DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which give rise to immediate cause (a), stating the underlying cause lost. _____		INTERVAL BETWEEN ONSET AND DEATH 20 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS A JTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (if this hospital) attended the deceased from Oct. 13, 1967 , to Nov. 14, 19 67 that (s) (we) last saw the deceased alive on Nov. 14 19 67 , and that death occurred at 105A M. from causes and on the date stated above.					
22a. SIGNATURE <i>Perry Ah-Tye</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Nov. 14, 1967	
22c. PHYSICIAN'S NAME (Type) Perry Ah-Tye, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11/15/67	23c. NAME OF CEMETERY OR CREMATORY Removal		23d. LOCATION (City or Town) (County) (State) Chicago, Illinois	
24. FUNERAL DIRECTOR Falls Church Funeral Home 1102 West Broad Street, Falls Church, Va.		25a. REC'D BY REGISTRAR NOV 16 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

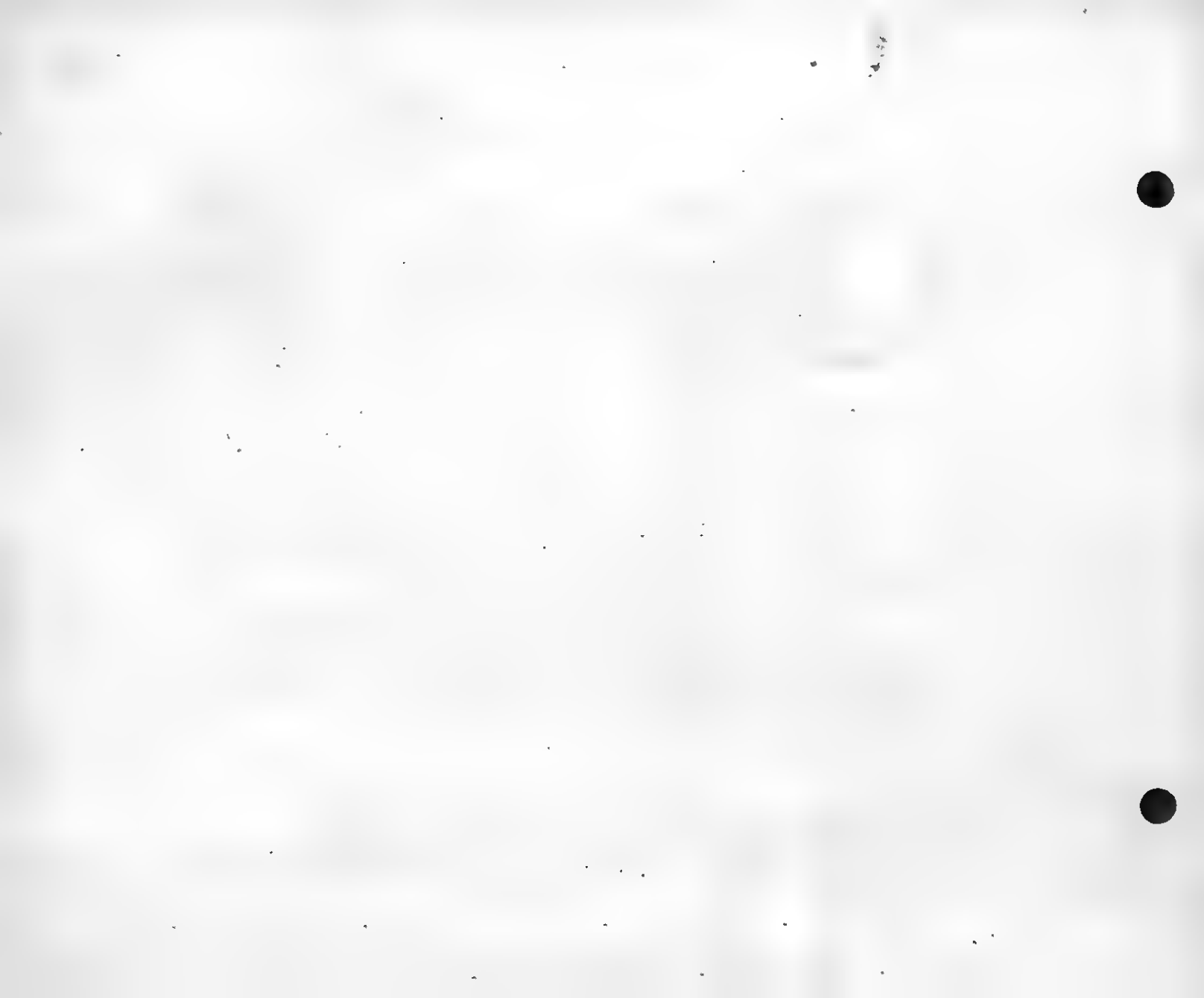
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15578

15574

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>519 Kerwin Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Naylor</u> Last <u>Estep</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1967</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-93</u>	9. AGE (In years last birthday) <u>74</u> yrs.	10. FUND 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Benjamin N. Estep</u>		14. MOTHER'S MAIDEN NAME <u>Eliz. A. Eaton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-07-0231-A</u>	
17. INFORMANT <u>Etta J. Estep</u>		Address <u>519 Kerwin Road Silver Spring, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
22. DATE SIGNED <u>Nov. 20, 1967</u>				23. NAME OF EXAMINER <u>Belden R. Reap, M.D.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pompey, Inc.</u>				25. REC'D BY REGISTRAR <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Catholic Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Brownstown, Md.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pompey, Inc.</u>		ADDRESS <u>9434 Frederick Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



15579

CERTIFICATE OF DEATH

15575

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst tut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN TB <u>8 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>802 Bowie Rd-</u>	
3 NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>F</u> Last <u>FAHEY</u>		4 DATE OF DEATH Month <u>Nov</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-11</u> 9. AGE (In years last birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WHEELDEX CORP.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SALESMAN</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Maryland-Allegany</u>		12 C.T. ZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael P. Fahey</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth McDann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes Army</u>		16. SOCIAL SECURITY NO <u>719-16-3802</u>	
17. INFORMANT <u>Wife</u> Address <u>Same as Item 2.</u>		18. CAUSE OF DEATH (Enter on y ope cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>UREMIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTERCAPILLARY GLOMERULOSCLEROSIS (Kimmelstiel)</u>		<u>home years</u>	
(c) <u>DIABETES MELLITUS (Long-standing)</u>		<u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19, 1967</u> to <u>Nov. 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 19, 1967</u> , and that death occurred at <u>5 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Bowditch Hunter, Jr.</u> M.D.		22b. DATE SIGNED <u>Nov. 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. BOWDITCH HUNTER, JR.</u>		22d. ADDRESS <u>50 W. Edmonston Dr. Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15580

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15576

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH DC			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN., & HOSPITAL				d STREET ADDRESS 2024 14TH AVE		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ISADORE Middle (NMN) Last FEINSTEIN				4 DATE OF DEATH Month 11 Day 1 Year 1967			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/25/14		9. AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b KIND OF BUSINESS OR INDUSTRY STATE FURNITURE		11. BIRTHPLACE (Country & State, or foreign country) RUSSIA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME MAX FEINSTEIN				14 MOTHER'S MAIDEN NAME SARAH BUBESLOVSKY			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 577-09-7675		17 INFORMANT Address HOSPITAL RECORDS			
18 CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE OF EMPHYSEMATOUS BLEB & RT. PULMONARY COLLAPSE. DUE TO (b) ASTHMA, EMPHYSEMA, & ABSENCE OF FUNCTIONING LF. PULMONARY TISSUE DUE TO (c) SECONDARY TO POST-TUBERCULOUS THERAPY							INTERVAL BETWEEN ONSET AND DEATH 4 HOURS
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE ONSET ON GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE , 1961, to NOV 1 , 1967, that (I) (we) last saw the deceased alive on NOV 1 , 1967, and that death occurred on NOV 1 1967, from causes and on the date stated above.							
22a SIGNATURE Robert L. Krichmar				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED NOV 1 1967	
22c PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR				22d ADDRESS 7733 ARASKA AVENUE N.W., WASHINGTON D.C. 20012			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 11-3-67		23c NAME OF CEMETERY OR CREMATORY GEORGETOWN CEMETERY		23d LOCATION (City or Town) (County) (State) Hyattsville, M.D.	
24 FUNERAL DIRECTOR Joseph Heccephane				ADDRESS 4217-9th Ave		25a REC'D BY REGISTRAR DATE NOV 3 1967	
				25b REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

15577

1 PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN lb <u>1 day</u>		d. STREET ADDRESS <u>9119 Manchester Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Fischer, Charlotte</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Feb. 28, 1887</u>
9 AGE (In years last birthday) <u>78</u> yrs.		10 IF UNDER 1 YEAR Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Austria</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Michael Fast</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Hahn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Leonore Fischer Raab</u>		Address <u>9039 Silver Spring Pkwy S.S.Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cute myocardial infarction</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCD & Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>approx 3 years</u> <u>approx 4 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>october</u> , 1964, to <u>Nov. 22</u> , 1967, that (I) <u>(we)</u> last saw the deceased alive on <u>Nov. 22</u> , 1967, and that death occurred at <u>10:56</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen</u> M.D.		22b. DATE SIGNED <u>Nov. 22, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 26, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Bethesda, MD</u>
24. FUNERAL DIRECTOR <u>Bernard Danzalsky & Sons</u>		25a. REC'D BY REGISTRAR <u>3501-14th Street, N.W. Washington, D.C. 20004</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>		DATE <u>NOV 27 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

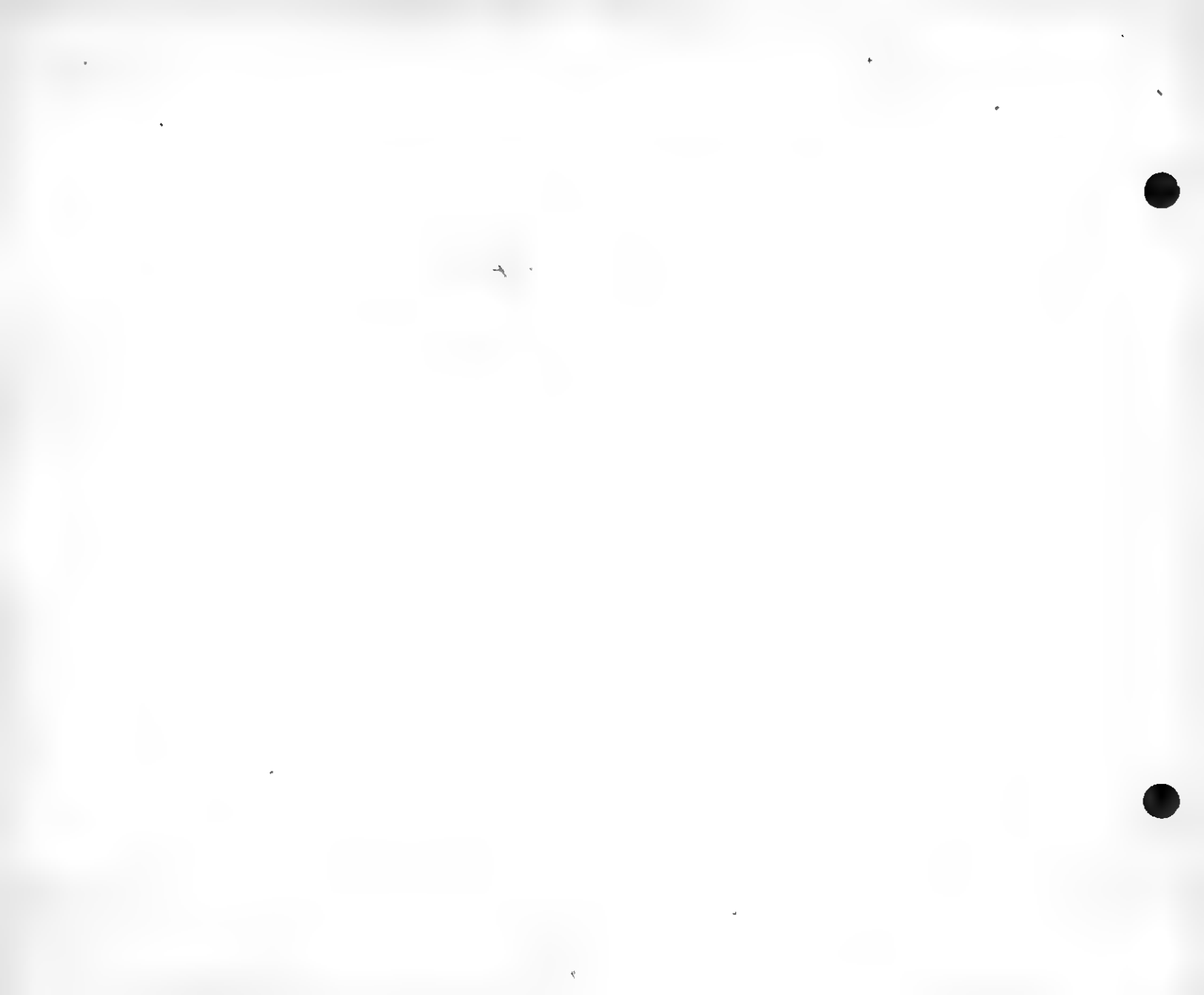
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15582

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15578

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY <u>4 YRS</u>		d. STREET ADDRESS <u>5014 Battery Lane</u>	
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>14326 New Hampshire Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>RUTH A. FISCHER</u>		4 DATE OF DEATH <u>Nov. 10 1967</u>	
5 SEX <u>Fe</u>	6 COLOR OR RACE <u>CAUC</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 10, '99 67</u>
9 AGE (In years) <u>67</u> Months <u> </u> Days <u> </u> M.in <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Office work</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11 BIRTHPLACE (State or foreign country) <u>Louisiana</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>John Fischer</u>	
14 MOTHER'S MAIDEN NAME <u>Annie Weiss</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO. <u>Unknown</u>		17 INFORMANT <u>Mrs. A.F. Rosendorn (above) niece</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Insufficiency</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u> </u> Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		CHIEF MED. CA. EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>Nov. 10, 1967</u>		DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/> Address (City, town, or county) <u> </u>	
23a. BURIAL (CREMATION, etc.) <u>Burial</u>	23b. DATE THEREOF <u>11-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Garden of Memories</u>	23d. LOCATION (City or Town) (County) (State) <u>New Orleans Louisiana</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>3557 Wisconsin Ave Bethesda, MD</u>		25a. REC'D. BY REGISTRAR <u>Nov 14 1967</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



Cleared by Dr. Reap

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

15583

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15579

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY in 1b <u>Hyattsville</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hosp</u>		d STREET ADDRESS <u>6729 Conley Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Daphne Jane Fletcher</u>		4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-67</u>
9a AGE (in years lost birthday) <u>9 mos</u>		9b IF UNDER 1 YEAR Months <u>3</u> Days <u>4</u> Hours <u></u> Min. <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b KIND OF BUSINESS OR INDUSTRY <u></u>	
11 BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12 CITIZEN OF WHAT COUNTRY? <u></u>	
13 FATHER'S NAME <u>Frances X. Fletcher</u>		14 MOTHER'S MAIDEN NAME <u>Gretchen Smith</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>7545 Congenital Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u></u> (c) <u></u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>11-14</u> , 19 <u>67</u> , to <u>11-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-14</u> , 19 <u>67</u> , and that death occurred at <u>6:45</u> M, from causes and on the date stated above			
22a SIGNATURE <u>S - Mahallati</u>		22b DATE SIGNED <u></u>	
22c PHYSICIAN'S NAME (Type) <u>Salaheddin Mahallati</u>		22d ADDRESS <u>1000 LEBNON ST</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>11-20-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL</u>	23d LOCATION (City or Town) (County) (State) <u>WASHINGTON D.C.</u>
24 FUNERAL DIRECTOR <u>Francis J. Jalkins</u>		25a REC'D BY REGISTRAR DATE <u>NOV 20 1967</u>	
25b REGISTRAR'S SIGNATURE <u></u>			

15584

CERTIFICATE OF DEATH

15580

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN it	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d STREET ADDRESS <u>10306 Haywood Drive</u>	
3 NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>N</u> Last <u>Fouke</u>		4 DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/20/97</u>
9 AGE (In years last birthday) yrs <u>70</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u></u> Min. <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Rock Engineering</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>William Fouke</u>		14 MOTHER'S MAIDEN NAME <u>Carrie McCoughney</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16 SOCIAL SECURITY NO <u>288-05-9350</u>	
17 INFORMANT <u>Maryl G. Fouke - wife - 10306 Haywood Drive</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized metastatic</u> DUE TO (b) <u>Bronchogenic Carcinoma of</u> DUE TO (c) <u>Left Lung</u>			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>pm</u> <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>61</u> to <u>Nov.</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Nov. 20</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> AM, from causes and on the date stated above			
22a SIGNATURE <u>Elden R. Reap</u>		22b DATE SIGNED <u>Nov. 21, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>ELDEN R. REAP, M.D.</u>		22d ADDRESS <u>Wheaton, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>11/24/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Ottawa Hills m. Pk.</u>		23d LOCATION (City or Town) (County) (State) <u>Toledo, Ohio</u>	
24 FUNERAL DIRECTOR <u>Ly on Hecker funeral Home Rockville, Md</u>		25a REC'D BY REG STRAR <u>DATE NOV 24 1967</u>	
25b REGISTRAR'S SIGNATURE <u>J. J. Jones Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #0-80 11/15/67 rh

CERTIFICATE OF DEATH

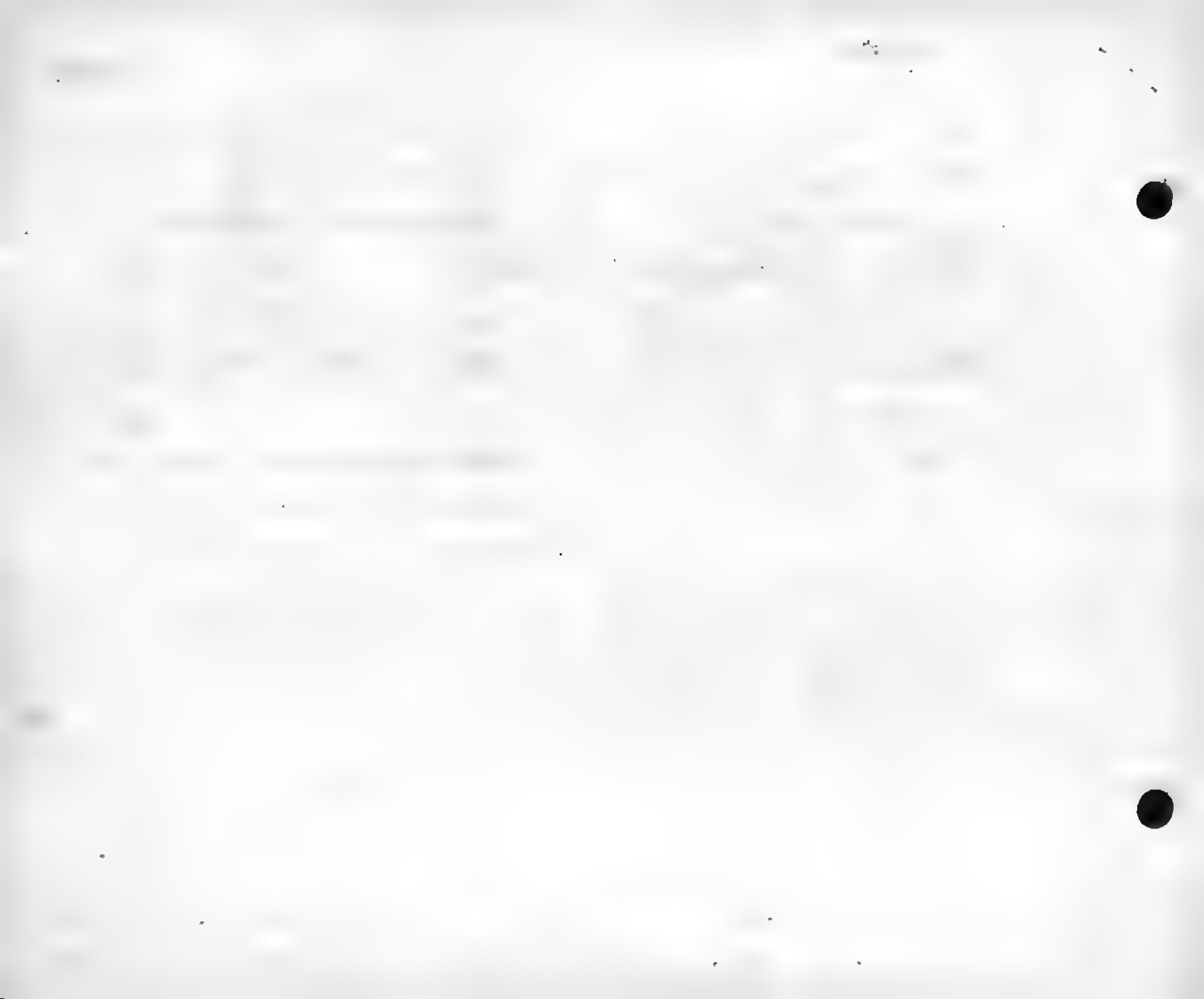
15585

15581

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>12h. 35 min.</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
3 NAME OF DECEASED (Type or print) <i>Charles A. Frohne</i>		4 DATE OF DEATH Month <i>Nov.</i> Day <i>6</i> Year <i>1967</i>	
5 SEX <i>M</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>11/8/04</i> 9 AGE (In years last birthday) <i>67 1/2 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Long Island N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Karl Frohne</i>		14. MOTHER'S MAIDEN NAME <i>Augusta Julia Kulbartat</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>055-05-5840</i>	
17. INFORMANT <i>Helen Smallwood</i>		Address <i>4214 Rockledge Silver Spring</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction, posterior wall, recent and old,</i> DUE TO (b) <i>coronary arteriosclerosis and coronary thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i></i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 6</i> , 19 <i>67</i> , to <i>Nov. 6</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11/6</i> 19 <i>67</i> , and that death occurred at <i>6:30 PM</i> , from causes and on the date stated above			
22a. SIGNATURE <i>Stanley Bialek</i>		22b. DATE SIGNED <i>11-7-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>STANLEY BIALEK</i>		22d. ADDRESS <i>8218 Wisconsin Ave. Bethesda, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11-8-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>NOV 13 1967</i>	25b. REGISTRAR'S SIGNATURE <i>R Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

15588

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15582

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall Nursing Home</u>		d. STREET ADDRESS <u>1001 Rockville Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>First EUGENE I. Last FRANKLIN</u>		4 DATE OF DEATH <u>NOVEMBER 15</u> 19 <u>67</u> Month Day Year	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1900</u>
9 AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Lexington, N. Carolina</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Calvin M. Bouknight</u>		14 MOTHER'S MAIDEN NAME <u>Anna C. Bouknight</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>224-72-4356</u>	
17 INFORMANT <u>Mrs. Frances E. Franklin-Item #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (d)) PART I. DEATH WAS CAUSED BY <u>4200</u> IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>104 1/2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-1</u> , 19 <u>65</u> , to <u>11-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-14</u> , 19 <u>67</u> , and that death occurred at <u>2:10 A.M.</u> from causes on the date stated above.			
22a. SIGNATURE <u>Henry K. London</u>		22b. DATE SIGNED <u>11-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry K. London</u>		22d. ADDRESS <u>5206 NORWAY DR. CHEVY CHASE, MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>11/16/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24 FUNERAL DIRECTOR <u>Rockville</u>		25a REC'D BY REGISTRAR <u>NOV 17 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

4/18/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15587

15583

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 'b <u>6 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>		e. STREET ADDRESS <u>1316 CHURCH HILL DRIVE</u> <u>XXXXXXXXXXXXXXXXXXXX</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Fried</u> Middle Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-XX 91</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales man</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md. BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID FRIED</u>		14. MOTHER'S MAIDEN NAME <u>GERTRUDE FRIED</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-05-57251</u>	
17. INFORMANT <u>MRS. RUTH WISEMAN</u>		Address <u>1316 CHURCH HILL DRIVE #8</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>arteriosclerosis, coronary.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic arteriosclerosis, & chronic ischemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>50 hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> , 19 <u>67</u> , to <u>11/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> , 19 <u>67</u> , and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel R. Kison</u> M.D.		22b. DATE SIGNED <u>11/17/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MIKRO KODESH BETH ISRAEL</u>	23d. LOCATION (City or town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD</u>		25a. REC'D BY REGISTRAR <u>DATE NOV 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J...</u>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

155889

CERTIFICATE OF DEATH

15584

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH <i>HOLY CROSS HOSPITAL</i>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)			
a. COUNTY <i>MONTGOMERY</i> MARYLAND				a. STATE <i>MARYLAND</i> b. COUNTY <i>PRINCE GEORGES</i>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<i>SILVER SPRING</i>		<i>21 days.</i>		<i>HYATTSVILLE.</i>			
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>HOLY CROSS HOSPITAL</i>				<i>620 Sheridan, ST.</i>			
3 NAME OF DECEASED (Type or print) <i>LENA B FRIEDENBERG</i>				4 DATE OF DEATH <i>11 3 1967</i>			
5 SEX <i>Female</i>		6 COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <i>10-15-91</i>	
9 AGE (in years last birthday) <i>76</i> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
<i>HOUSEWIFE</i>		<i>-</i>		<i>NEW YORK</i>		<i>U.S.A.</i>	
13 FATHER'S NAME <i>JACOB KEROES</i>				14 MOTHER'S MAIDEN NAME <i>ROSE COHEIN</i>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>HARRY EISENSTADT</i> Address <i>3917-15BELL, ST. S.S. MD.</i>			
18 CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c))		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4201</i> DUE TO <i>CONGESTIVE HEART FAILURE</i>						<i>20 DAYS</i>	
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <i>CORONARY ARTERY DISEASE</i>				<i>10 YRS</i>	
(c)							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
<i>11/3/67</i>		<i>11/3</i>		<i>67</i>		<i>67</i>	
21 I certify that (I) (this hospital) attended the deceased from <i>11/3</i> , 19 <i>67</i> , to <i>11/3</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11/3</i> , 19 <i>67</i> , and that death occurred at <i>3:30</i> P.M., from causes and on the date stated above							
22a SIGNATURE <i>David Goldenberg</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <i>11/3/67</i>			
22c PHYSICIAN'S NAME (Type) <i>DAVID GOLDENBERG</i>		22d ADDRESS <i>10620 GEORGIA SILVER SPRING MD.</i>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <i>11/5/67</i>		23c NAME OF CEMETERY OR CREMATORY <i>GEO. WASH. CEM.</i>		23d LOCATION (City or town) (County) (State) <i>HYATTSVILLE, MD.</i>	
<i>BURIAL</i>		<i>11/5/67</i>		<i>GEO. WASH. CEM.</i>		<i>HYATTSVILLE, MD.</i>	
24 FUNERAL DIRECTOR <i>Goldberg Funeral Home</i>		ADDRESS <i>42179th DR NW</i>		25a REC'D BY REGISTRAR <i>Charles Judge</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
				DATE <i>NOV 6 1967</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15589

CERTIFICATE OF DEATH

15585

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>md.</u> b COUNTY <u>Mont. Co.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>1 hr. 35 min.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Infant Girl Frye</u>		4 DATE OF DEATH Month <u>Nov</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-16-67</u>
9 AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>25</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Robert Frye</u>	
14 MOTHER'S MAIDEN NAME <u>Thelma Gale</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT <u>Dr. Charles</u> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (1) (this hospital) attended the deceased from <u>11/16/67</u> , 19 <u>67</u> , to <u>11/16/67</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>11/16</u> 19 <u>67</u> , and that death occurred at <u>9:50 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Marjorie</u>		22b DATE SIGNED <u>11/16/67</u>	
22c PHYSICIAN'S NAME (Type) <u>MARJORIE MONROE</u>		22d ADDRESS <u>1003 Spring St S 10616py Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
<u>Interment</u>	<u>11-22-67</u>	<u>Suburban Hospital</u>	<u>Bethesda, Md.</u>
24 FUNERAL DIRECTOR <u>Charles C. Carter, Admin.</u>		25a REC'D BY REG. STRAR <u>NOV 30 1967</u>	
ADDRESS <u>Suburban Hospital</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with funeral home's report. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

15590

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15586

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institut or Residence before adm ssion) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c LENGTH OF STAY IN 1b <u>40 mins</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>			d STREET ADDRESS <u>45-60 So CHELSEA ST</u> LANE		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS XAVIER FUHRMAN</u>			4 DATE OF DEATH Month Day Year <u>NOV 16 1967</u>		
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>NOV 25 1894</u>	9 AGE (In years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTOMS</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>		11 BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13 FATHER'S NAME <u>WILLIAM FUHRMAN</u>		
14 MOTHER'S MAIDEN NAME <u>ADA SWEETMAN</u>			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes IT WW</u>		
16 SOCIAL SECURITY NO			17 INFORMANT Address <u>KATHLEEN FUHRMAN - WIFE</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 pm</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 9 WAJ. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Name form factory, street, office bldg, etc.)	20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John A. Ball</u> MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>Nov 16/67</u>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b DATE THEREOF <u>11-20-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Culpeper Nat'l. Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Culpeper, Va.</u>		
24 FUNERAL DIRECTOR <u>Joseph Jawler's Sons, Inc. 5130 Wash. Ave. N.W.</u>		25a REC'D BY REGISTRAR DATE <u>NOV 20 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



15591

Item 22c & d Film 15591/15587
CERTIFICATE OF DEATH

15587

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u> c. LENGTH OF STAY IN b. <u>Bethesda/ Chevy Chase</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda/ Chevy Chase</u> d. STREET ADDRESS <u>3704 Hunt Valley St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Joseph Boyd Fuller</u> First Middle Last		4 DATE OF DEATH <u>Nov. 14 1967</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 19 1889</u> 9. AGE (In years lost birthday) <u>78</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11 BIRTHPLACE (County & State, or foreign country) <u>MORRISTOWN N.J.</u> 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13 FATHER'S NAME <u>Theodore Mulford</u>		14 MOTHER'S MAIDEN NAME <u>BESSIE BENTLEY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u> </u>	
17 INFORMANT <u>Mrs. Edwin C. Hagg, Chevy Chase, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonitis - acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Advanced generalized arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/14/67</u> , 19 <u>67</u> , to <u>11/14/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/14/67</u> , 19 <u>67</u> , and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ronald W. Barr</u>		22b. DATE SIGNED <u>11/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RONALD W. BARR, M.D.</u>		22d. ADDRESS <u>10401 OLD GEORGETOWN RD BETHESDA, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>11/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Joseph Gaultier's Sons</u>		25a. REC'D BY REGISTRAR <u>5130 WILKINS AVE</u> DATE <u>NOV 20 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15588

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> Maryland		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>Brookville</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e STREET ADDRESS <u>19923 Zion Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Howard S. Gant</u>		4 DATE OF DEATH <u>November 12 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 17 1921</u>
9 AGE (In years birthday) yrs <u>46</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Service Foreman</u>		10b KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11 BIRTHPLACE (State or foreign country) <u>Montgomery Co. Md.</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>Thomas Gant</u>		14 MOTHER'S MAIDEN NAME <u>Malinda Diggs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give year or dates of service) <u>WW II</u>		16 SOCIAL SECURITY NO <u>WW II</u>	
17 INFORMANT <u>Address</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Extreme Injuries</u> DUE TO (b) <u>including Skull fractures</u> DUE TO (c) <u>with Exsanguination</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DEATH CONDITION GIVEN IN PART I(a) <u>Deceased, Driver, lost control of car which hit pole</u>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW ACCURRED (Give nature of injury in Part I or Part of item 18) <u>Street Brookville, Md</u>	
20c TIME OF INJURY Month, Day, Year <u>Nov 11 1967</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>Nov. 12, 1967</u>	
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>11/15/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u>		23d LOCATION (City or Town) (County) (State) <u>MT. ZION, MONTG. MD.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Swarden</u> ROCKVILLE, MD.		25a REC'D BY REGISTRAR DATE <u>NOV 16 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>B. L. Swarden</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

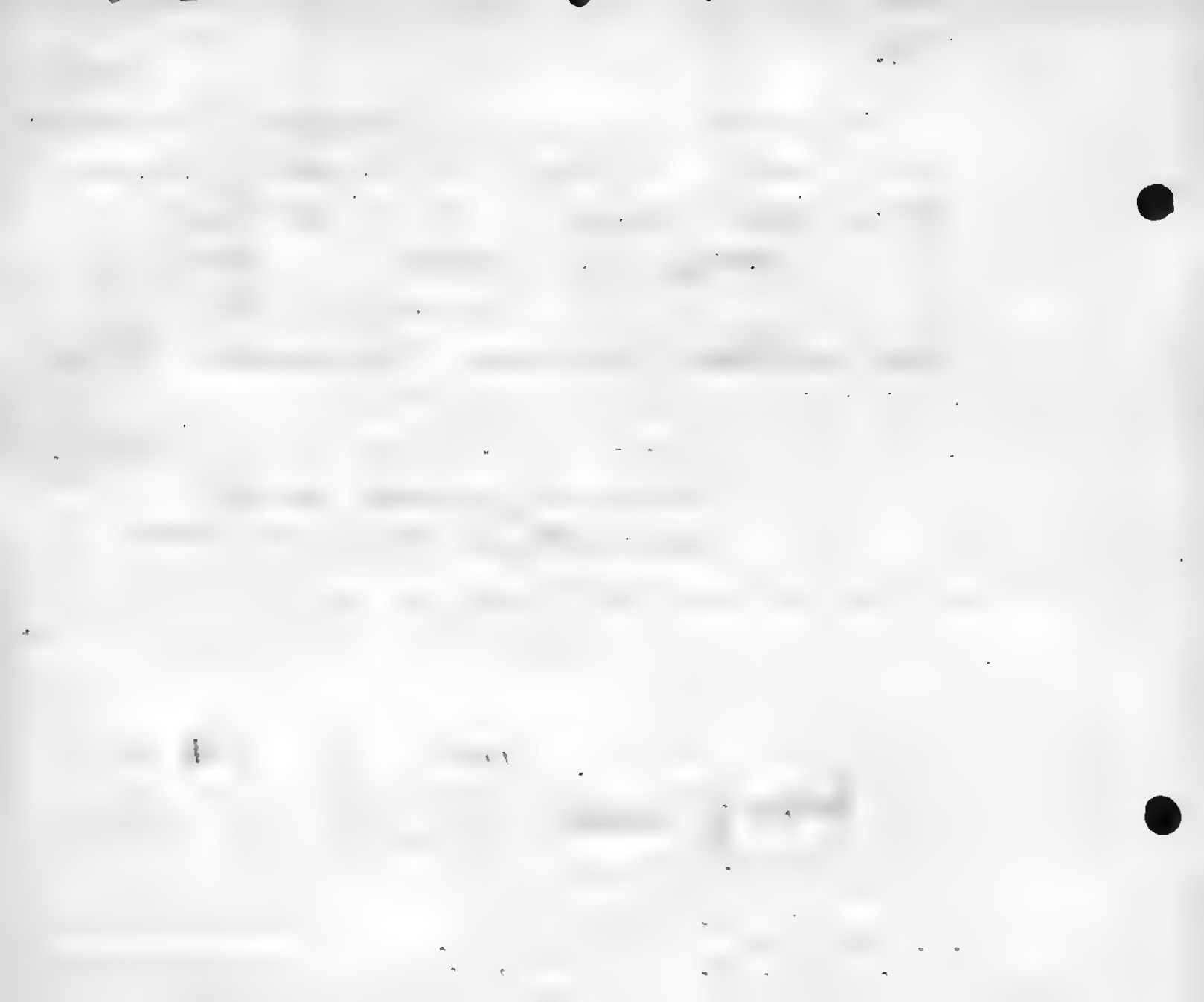
VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

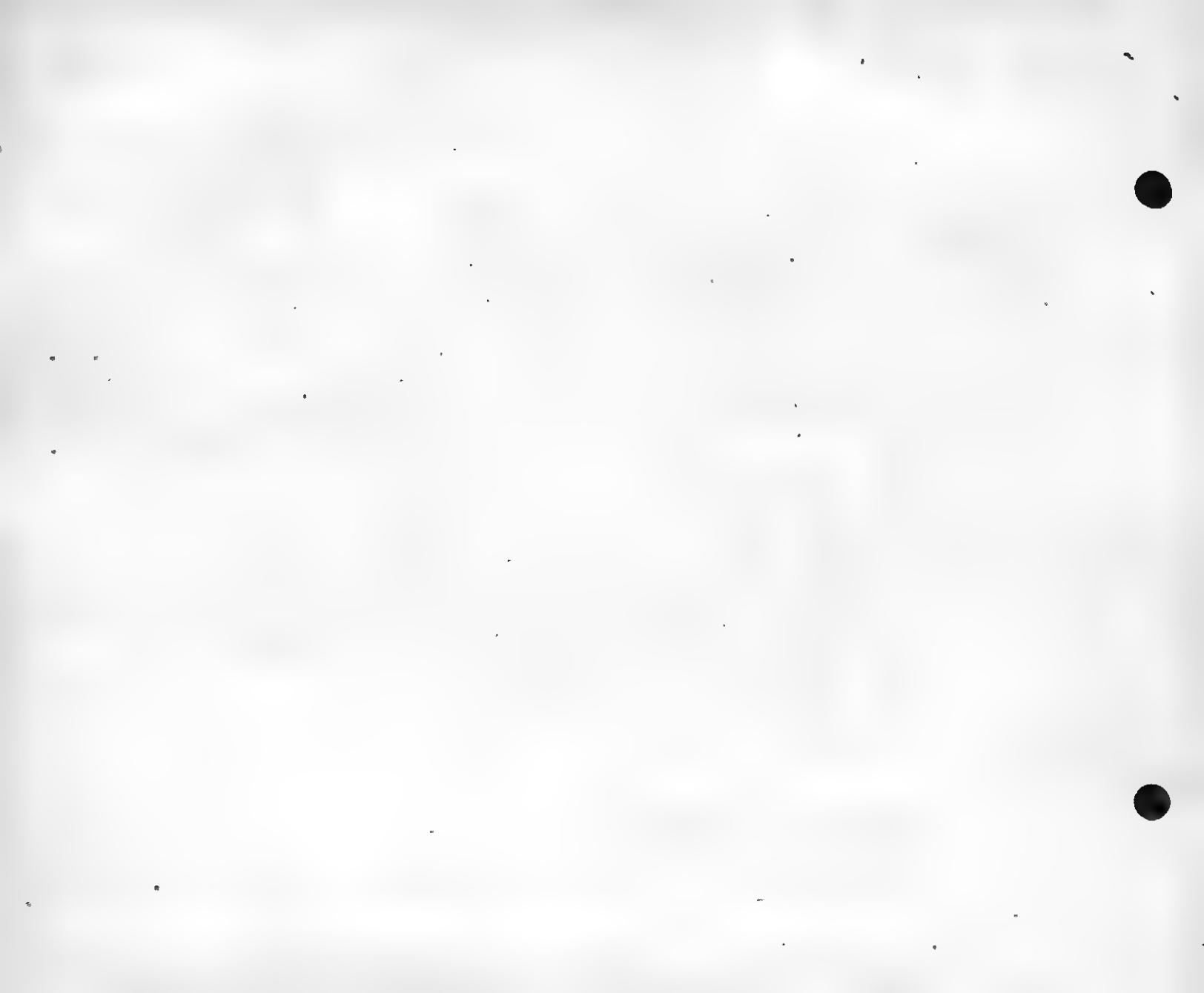
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>	
c. LENGTH OF STAY in 1b <u>8 days</u>		d. STREET ADDRESS <u>2101 Hilda Rose Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>W.</u> Last <u>Garis</u>	4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1891</u> 76 yrs.
9. AGE (in years last birthday) Months Days Hours Min.		10. AGE (in years last birthday) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor (Retired) U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cornelius Garis</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Fleming</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>266-44-5700</u>	
17. INFORMANT <u>Mrs. Eva Garis</u>		Address <u>2101 Hilda Rose Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular arrest</u> 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>secondary carcinoma</u> (c) <u>metastasis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> , 19 <u>67</u> to <u>11/2</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/1</u> , 19 <u>67</u> , and that death occurred at <u>5:35 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur J. Willets</u>		22b. DATE SIGNED <u>11/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur J. Willets</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>November 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Easton Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Easton, Pennsylvania</u>
24. FUNERAL DIRECTOR <u>J. B. Thomas & Son, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE	
DATE <u>NOV 8 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cancer notified (Guthrie mo.)

MONTGOMERY COUNTY, MARYLAND											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. LENGTH OF STAY IN 1b <u>18 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6800-Connecticut Avenue</u>						d. STREET ADDRESS <u>6800-Connecticut Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>EUFROSYNE DOLLY GEORGE</u>			4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1967</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH <u>December 18, 1918</u>			9. AGE (In years last birthday) <u>48</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 1 MONTHS Months <u>4</u> Days <u>8</u> Hours <u>15</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		
13. FATHER'S NAME <u>John Theodore</u>						14. MOTHER'S MAIDEN NAME <u>Maria Stamos</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>			17. INFORMANT <u>Husband</u>			Address <u>Same as Item 2.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 7201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Sclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>None</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u> 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>January 1957</u> to <u>November 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>November 1967</u> , and that death occurred at <u>6:00</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>James M. Loftus</u>						22b. DATE SIGNED <u>November 6, 1967</u>			22c. PHYSICIAN'S NAME (Type) <u>JAMES M. LOFTUS</u>		
22d. ADDRESS <u>5415-Connecticut Ave N.W. Washington</u>						22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. ADDRESS <u>5415-Connecticut Ave N.W. Washington</u>		
23a. BURIAL, CREMATION, REMOVAL <u>Cremation 11-6-67</u>			23b. DATE THEREOF <u>11-6-67</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>			23d. LOCATION (City, town, or county) (State) <u>Suitland Prince Georges Md.</u>		
24. FUNERAL DIRECTOR <u>Robert A Pumphrey 7557 Wisconsin Ave</u>						25a. REC'D BY REGISTRAR <u>NOV 9 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
25c. ADDRESS <u>Bethesda, Md</u>						25d. ADDRESS <u>Bethesda, Md</u>			25e. ADDRESS <u>Bethesda, Md</u>		



CERTIFICATE OF DEATH

15595

15591

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 6 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital			d. STREET ADDRESS 1106 Ednor Road		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Leo Middle Earl Last George			4 DATE OF DEATH Month November Day 14 Year 1967		
5 SEX Male	6. COLOR OR RACE White	7 MARRIAGE NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/88		9 AGE (In years last birthday) 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Post office		11. BIRTHPLACE (County & State, or foreign country) Wisconsin	
13. FATHER'S NAME Benjamin B. George			14. MOTHER'S MAIDEN NAME Mary Atkins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Medical Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA AND PULMONARY EDEMA DUE TO (b) CEREBRAL HEMORRHAGE, LEFT DUE TO (c) ARTERIOSCLEROTIC VASCULAR DISEASE					INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 4 DAYS 20 YRS
PART 1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) BRONCHO PNEUMONIA - TERMINAL					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from AUGUST , 19 64 , to 11-14 , 19 67 , that (2) (we) last saw the deceased alive on 11-13 , 19 67 , and that death occurred at 10:00 AM , from causes and on the date stated above.					
22a. SIGNATURE Donald R. Lewis			22b. DATE SIGNED 11-14-67		
22c. PHYSICIAN'S NAME (Type) Donald Lewis, M.D.			22d. ADDRESS Cloverly Road, Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/17/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	23d. LOCATION (City or town) (County) (State) Cooper Manor, Md.		
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.			25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15592

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 8hrs./4mins.		2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
3 NAME OF DECEASED (Type or print) William Henry Gittings		4 DATE OF DEATH Month November Day 15 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Month 11 Day 25 Year 1925
9a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		9b. STREET ADDRESS 7903 Garland Ave. #2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Plumbing and Heating		10b. KIND OF BUSINESS OR INDUSTRY Ind.	
11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. Gittings		14. MOTHER'S MAIDEN NAME Maggie Truxton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes - National Guard 7-10-57-09-64		16. SOCIAL SECURITY NO. 577-09-6442	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY CLEAR HILL CEM		23d. LOCATION (City or town) (County) (State) SUITLAND MD.	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO		25a. REC'D BY REGISTRAR NOV 20 1967	
ADDRESS RIVERDALE, MD		25b. REGISTRAR'S SIGNATURE Charles Jones	



15594

15597

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Alabama b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 198 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		e. STREET ADDRESS 1104 Astor Street	
3. NAME OF DECEASED (Type or print) First Douglas Middle Loyd Last Godbee		4. DATE OF DEATH Month November Day 18 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 April 1955
9. AGE (in years last birthday) 12 yrs		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (County & State or foreign country) France		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Loyd Godbee, Jr.		14. MOTHER'S MAIDEN NAME Mary Lord	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record		18. ADDRESS The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Thrombocytopenia DUE TO (c) Acute Lymphocytic Leukemia			INTERVAL BETWEEN ONSET AND DEATH immediate 10 months 10 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diffuse Pulmonary Hemorrhage and Candidiasis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 4, 1967 , to Nov. 18, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 18, 1967 , and that death occurred at 7:40 M. from causes on and on the date stated above.			
22a. SIGNATURE Robert G. Caw, Jr., M.D.		22b. DATE SIGNED Nov. 18, 1967	
22c. PHYSICIAN'S NAME (Type) Robert G. Caw, Jr., M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF Nov. 19, 1967	23c. NAME OF CEMETERY OR CREMATORY Rockville, Maryland	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR 1331 Rockville Pike		25a. REC'D BY REGISTRAR NOV 21 1967	
25b. REGISTRAR'S SIGNATURE 1331 Rockville Pike		25c. REGISTRAR'S SIGNATURE 1331 Rockville Pike	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15598

15593

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 21 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		e. STREET ADDRESS R. D. #2	
3. NAME OF DECEASED (Type or print) First MYRTLE Middle ALICE Last GODFREY		4. DATE OF DEATH Month 11 Day 2 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-84
9a. AGE (In years lost birthday) yrs 83		IF UNDER 1 YEAR Months Days Hours Min.	
9b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		2. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH HOLMES		14. MOTHER'S MAIDEN NAME MOLLY HOLMES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT MEDICAL RECORD DEPT.		Address	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Failure DUE TO (b) Obstruction, common duct DUE TO (c) Carcinoma, head pancreas		INTERVAL BETWEEN ONSET AND DEATH Days mos. ?	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Diabetes Mellitus ② Nephrosclerosis		9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1967 to 11-2, 1967 , that (I) (we) last saw the deceased alive on 11-2-67 , and that death occurred at 3:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher M.D.		22b. DATE SIGNED 11-3-67	
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.		22d. ADDRESS GAITHERSBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE THEREOF 11-5-67	23c. NAME OF CEMETERY OR CREMATORY Laytonsville	23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md.
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 7 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15599

15595

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>Washington Sanitarium and Hospital</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8207 Grubb Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
3. NAME OF DECEASED (Type or print) First <u>ALFRED</u> Middle <u>GOLDENZIEL</u> Last 4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1967</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21, 1878</u>		9. AGE (in years last birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u> Hours <u>67</u> Min											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>															
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>502-46-7358A</u>		17. INFORMANT <u>Leon Weinraub</u>		Address <u>1107 Dale Drive, Silver Spring</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>4321</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ASCRO</u> DUE TO (c) <u>years.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> , 19 <u>66</u> to <u>Nov. 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 1</u> , 19 <u>67</u> , and that death occurred at <u>6:41 AM</u> , from causes and on the date stated above.																							
22a. SIGNATURE <u>Marvin Schneider</u> 22c. PHYSICIAN'S NAME (Type) <u>Marvin Schneider, MD</u>														22b. DATE SIGNED <u>November 2, 1967</u>									
22d. ADDRESS <u>911 Silver Spring Ave., Silver Spring, Md</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>												23b. DATE THEREOF <u>11-5-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden Falls Church Virginia</u>				23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Donald M. Stein</u>				ADDRESS <u>232 Carroll</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											
Hebrew Memorial Funeral Home Wash., DC 20012																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MONTGOMERY											
1 PLACE OF DEATH a. COUNTY						2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
5. SEX						6. COLOR OR RACE					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>						8. DATE OF BIRTH					
9. AGE (In years last birthday)						10. IF UNDER 1 YEAR					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						11. BIRTHPLACE (County & State, or foreign country)					
12. CITIZEN OF WHAT COUNTRY?						13. FATHER'S NAME					
14. MOTHER'S MAIDEN NAME						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					
16. SOCIAL SECURITY NO						17. INFORMANT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Septicemia - Pneumonia</u> DUE TO (b) <u>Lupus Erythematosus</u> stating the underlying cause last (c) <u>Lupus Erythematosus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-6 days</u> <u>6-8 months</u>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>Nov 11</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Nov 10</u> , 19 <u>67</u> , and that death occurred at <u>5:35 AM</u> , from causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE THEREOF					
23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR					
25b. REGISTRAR'S SIGNATURE						DATE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15601

CERTIFICATE OF DEATH

15597

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenland		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Id. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C. PO 16	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6677 Mac Arthur Blvd		d. STREET ADDRESS 6677 Mac Arthur Blvd	
3. NAME OF DECEASED (Type or print) Mr. Christopher Granger		4. DATE OF DEATH Month Nov Day 21 Year 1967	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 25, 1885
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 21 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Mich		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George F. Granger		14. MOTHER'S MAIDEN NAME Helena Mabley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 579-60-2364	
17. INFORMANT Stephen I. Granger Son		Address Purcellville, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 4201 Myocardial Infarction IMMEDIATE CAUSE (a) Coronary Arterio Sclerosis DUE TO (b) 15 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1934 to Nov 21, 1967 , that (I) (we) lost saw the deceased alive on Nov 6, 1967 , and that death occurred at 11:34 AM , from causes on and the date stated above			
22a. SIGNATURE Worth B. Daniels M.D.		22b. DATE SIGNED Nov 21, 67	
22c. PHYSICIAN'S NAME (Type) WORTH B. DANIELS		22d. ADDRESS 2001 Eye St NW Washington 6, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF Nov 22, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Jos. Gawler Son's Inc. Wash, D.C.		25a. REC'D BY REGISTRAR Nov 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/67

Items 18-21 Film 395
12-13-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15598

15602

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN TB <u>1 year</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2013 Edgewater Parkway</u>				d. STREET ADDRESS <u>2013 Edgewater Parkway</u>			
3 NAME OF DECEASED (Type or print) <u>William NMN GRAY</u>				4 DATE OF DEATH <u>November 14 1967</u>			
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-1-21</u>	9 AGE (In years last birthday) <u>46</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>USMC</u>		11 BIRTHPLACE (State or foreign country) <u>CANADA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>
13 FATHER'S NAME <u>PERCY GRAY</u>				14. MOTHER'S MAIDEN NAME <u>ESTHER TIDY</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 1948-1967</u>		16 SOCIAL SECURITY NO <u>551-18-2167</u>		17 INFORMANT <u>Mary Gray</u> <u>2013 Edgewater Pkwy. Silver Spring, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure due to</u> <u>1702</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Barbiturate intoxication</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I):							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8) <u>Deceased, depressed, took overdose of barbiturate</u>				
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>11/14 1967</u> pm			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Walter E. Humphrey, Inc.</u> (City or town) (County) (State)			
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 17, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24 FUNERAL DIRECTOR <u>Walter E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

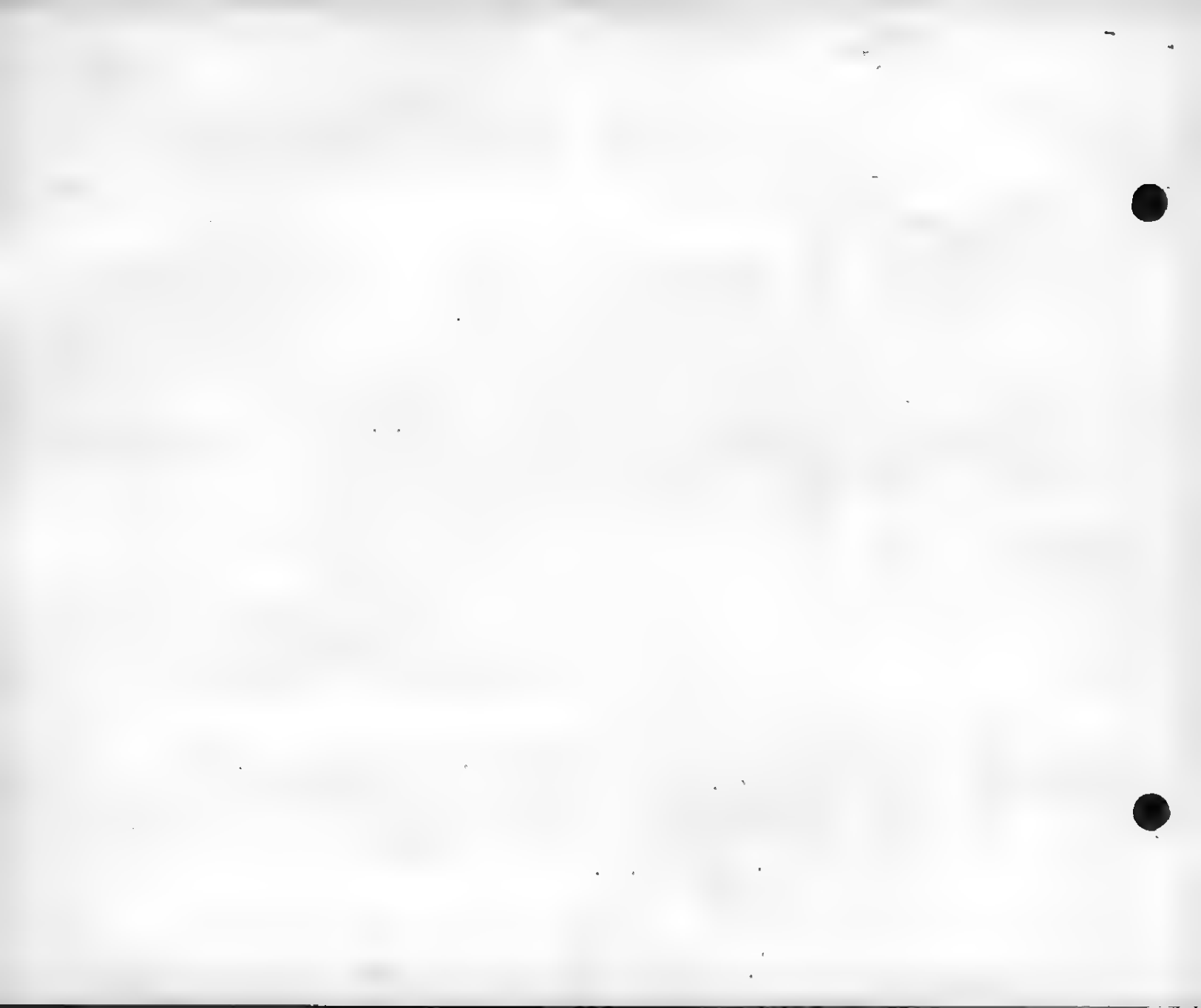
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15603

CERTIFICATE OF DEATH

17237

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital			d. STREET ADDRESS 4638 Livingston Road, S. E.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Kerri Ann GREAM			4. DATE OF DEATH Month Day Year November 30 1967		
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1967	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days Hours Min 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland	
13. FATHER'S NAME Horace Gream			14. MOTHER'S MAIDEN NAME Rita Marie Jobin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO N/A		17. INFORMANT S.E. Washington D.C. SGT Horace Gream, USMC, 4638 Livingston Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7546 Congestive Heart Failure DUE TO (b) Congenital Coarctation of the Aorta DUE TO (c) Probable Intrauterine Infection					INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 3 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> or work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (X) (this has to) attended the deceased from Nov. 27, 1967 to Nov. 30, 1967 , that (H) (we) last saw the deceased alive on Nov. 30, 1967 , and that death occurred at 1250 PM , from causes and on the date stated above.			
22a. SIGNATURE Gene P. Swartz		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 1, 1967	
22c. PHYSICIAN'S NAME (Type) Gene P. SWARTZ M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-4-67	23c. NAME OF CEMETERY OR CREMATORY Stewart Cemetery		23d. LOCATION (City or Town) (County) (State) Dexter, Kentucky	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland			25a. REC'D BY REGISTRAR DATE DEC 7 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15604

CERTIFICATE OF DEATH

15599

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c LENGTH OF STAY in 1b 2 years	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5418 Glenwood Road		d. STREET ADDRESS 5418 Glenwood Road	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Mary Middle E. Last Griffin		4. DATE OF DEATH Month Nov. Day 11 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1880 87 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 87
11. BIRTHPLACE (County & State, or foreign country) Ohio		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Deucher		14. MOTHER'S MAIDEN NAME Martha A. Griffith	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Son J. Lloyd Griffin		18. ADDRESS 8009 Glenbrook Rd. Bethesda, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO (b) Cerebral Vascular Insufficiency DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hip Fracture			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 15, 1967 to Nov. 11, 1967 , that (I) (we) lost saw the deceased alive on Nov. 10, 1967 , and that death occurred at 12:35 PM , from causes and on the date stated above			
22a SIGNATURE Stanley M. Bialek		22b DATE SIGNED Nov. 11, 1967	
22c. PHYSICIAN'S NAME (Type) STANLEY M. BIALEK		22d ADDRESS 8218 Wisconsin Ave. Beth. Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11-15-67	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION (City or Town) (County) (State) Suitland, Maryland
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a REC'D BY REGISTRAR DATE NOV 14 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE- HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

15605

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Filed 11/23/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15600

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY N 1b <u>1 Hr 45 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4318 Deland St</u>	
3 NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>Bordshell</u> Middle <u>Gummel</u> Last		4 DATE OF DEATH <u>Nov.</u> Month <u>1</u> Day <u>1967</u> Year	
5 SEX <u>male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1918</u> 9 AGE (In years last birthday) <u>79</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>PLACES FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>George Gummel</u>		14 MOTHER'S MAIDEN NAME <u>Boydell, Katherine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>Yes.</u>		16 SOCIAL SECURITY NO <u>579-01-0458</u>	
17 INFORMANT <u>(Son)</u> <u>Kenneth Gummel - Colony Rd.</u>		18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency - Acute</u> 4301	
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)	20f. City or town (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>11/2/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Washington, D. C.</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c LENGTH OF STAY IN 1b <u>MARYLAND</u> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium 5731 Grosvenor Lane</u>						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTG</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8909-GARLAND AVE</u> d STREET ADDRESS <u>TAKOMA PARK-MD</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <u>HARRY B HACKMAN</u>						4 DATE OF DEATH <u>NOV 23 1967</u>					
5 SEX <u>MALE</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 25-1880</u>		9 AGE (In years last birthday) <u>87</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>WOMELSDORT, Pa.</u>			12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13 FATHER'S NAME <u>HENRY T. HACKMAN</u>						14 MOTHER'S MAIDEN NAME <u>MARY A. KALER</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17 INFORMANT <u>W. M. HACKMAN</u> Address <u>1113 WATCHING AVE Prince Georges</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY 4500 IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>48 hr</u> <u>20 yrs</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/22</u> , 19 <u>67</u> to <u>11/23</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>11/22</u> , 19 <u>67</u> , and that death occurred at <u>5:30 PM</u> , from causes on and on the date stated above											
22a SIGNATURE <u>Ronald W. Barr</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b DATE SIGNED		
22c PHYSICIAN'S NAME (Type) <u>RONALD W. BARR, MD</u>						22d ADDRESS <u>10481 Old Georgetown Bethesda, Md.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <u>NOV. 27-1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>St. Ann's Church Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Prince Georges</u>					
24. FUNERAL DIRECTOR <u>Charles J. Waters</u>						25a REC'D BY REGISTRAR <u>Charles J. Waters</u>		25b REGISTRAR'S SIGNATURE <u>Charles J. Waters</u>			
DATE <u>NOV 27 1967</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15607

CERTIFICATE OF DEATH

15602

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c LENGTH OF STAY IN TB Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10820 Georgia Avenue		d. STREET ADDRESS 10820 Georgia Avenue	
3 NAME OF DECEASED (Type or print) Charles M. Hardesty		4. DATE OF DEATH Month November Day 4 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/22/15
9 AGE (In years lost birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov't. Employee	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles P. Hardesty		14. MOTHER'S MAIDEN NAME Olive Padgett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-09-8139	
17. INFORMANT Donald P. Hardesty, Adelphi, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia to Brain DUE TO (b) Leukemia - Lymphosarcoma DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 4y.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 3, 1967 to Nov 4, 1967 , that (I) (we) last saw the deceased alive on Nov 3, 1967 and that death occurred at 3 AM , from causes and on the date stated above			
22a SIGNATURE AZAD J. Vosgenian		22b ADDRESS 3701 Maxey Ave. NW - Wash. D.C.	
22c PHYSICIAN'S NAME (Type)		22d DATE SIGNED Nov 8/67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/7/67	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d LOCATION (City or town) (County) (State) Silver Spring, Maryland
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C. 20016		25a REC'D BY REGISTRAR Nov 9 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15608

15608

1 PLACE OF DEATH a. COUNTY <u>Mont. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN Institution <u>I.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pensington</u>	
f. STREET ADDRESS <u>4005 - Myers Mill Rd.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Pearl T. Harrison</u>		4 DATE OF DEATH <u>Nov. 25 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Colored</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 27, 1919</u>
9 AGE (In years last birthday) <u>47</u> yrs		F UNDER 1 YEAR <input type="checkbox"/> F UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Marshall Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Lea Belle Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia -</u> DUE TO <u>Cirrhosis of Liver -</u> DUE TO <u>Chronic Alcoholism -</u> (c) <u>lost</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18,)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		22. DATE SIGNED <u>11/26/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sandy Spring, Md.</u>	23d. LOCATION (City or Town) (County) (State) <u>Sandy Spring Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Sworden</u> <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 6 1967</u> 25b. REGISTRAR'S SIGNATURE <u>John S. Ball</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15603

15604

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>7400 Denton Rd.</u>		d. STREET ADDRESS <u>7400 Denton Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Elizabeth S. Hart</u>		4 DATE OF DEATH <u>November 17 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>July 14 1907</u>
9 AGE (in years last birthday) <u>60</u> yrs		10 IF UNDER 1 YEAR <u>17</u> Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Iowa</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Robert S. Alexander</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth S. Alexander</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>John A Bennett</u>		Address <u>7400 Denton Rd Bethesda</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fatty Metamorphosis of Liver Acute</u> DUE TO <u>Chronic Alcoholism</u> CONDITIONS if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John A Ball</u>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11-20-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 24 1967</u>	



15610

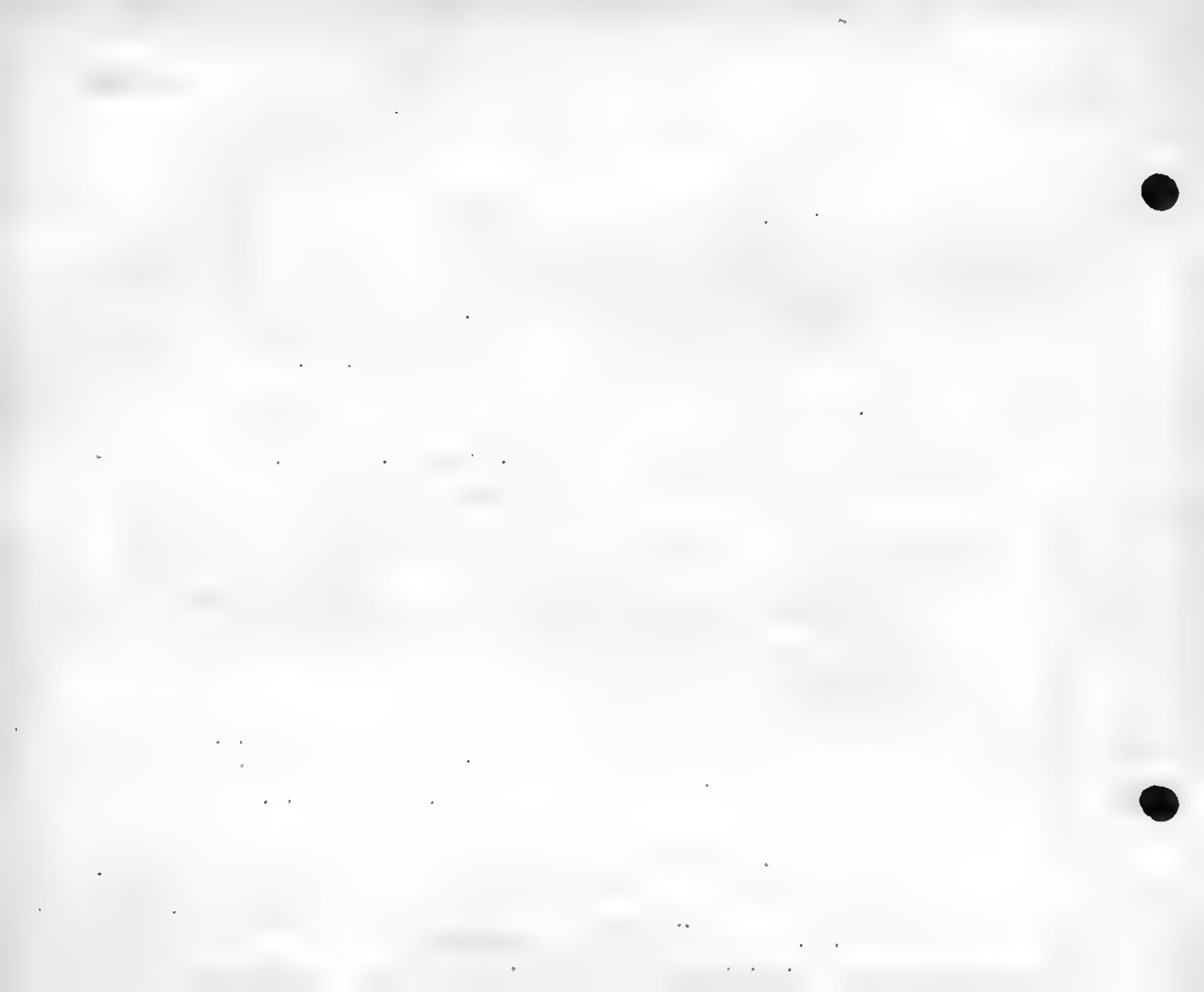
CERTIFICATE OF DEATH

15605

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm'ssion) a. STATE Virginia b. COUNTY			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Portsmouth			
c LENGTH OF STAY IN 1b 1 day				d STREET ADDRESS 205 Cedar Lane			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital,				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Mark Edward HEASTER				4 DATE OF DEATH Month Day Year November 2 19 67			
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH Nov. 1, 1967	9. AGE (In years last birthday) yrs 1	IF UNDER 1 YEAR Months Days hours Min.	IF UNDER 24 HRS hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Portsmouth, Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Heaster				14. MOTHER'S MAIDEN NAME Evangeline Griffith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Portsmouth Va. Dr. James M. Heaster, 205 Cedar Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7543 Congenital heart disease DUE TO (b) Mitral & Aortic valve atresia DUE TO (c) Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State) 5:00 P.M. 10:30 P.M.	
21. I certify that (A) (this hospital) attended the deceased from Nov. 2 , 19 67 , to Nov. 2 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 2 , 19 67 , and that death occurred at 10:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE Jerry J. Tomasovic		22b. DATE SIGNED 10:30 P.M.		22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/6/67		23c NAME OF CEMETERY OR CREMATORY CUNNINGHAM MEM. PARK		23d. LOCATION (City & Town) (County) (State) ST. ARBANS West Virginia	
24 FUNERAL DIRECTOR W. W. Chambers 1400 Chapin St., N.W. Washington, D. C.				25 REC'D BY REGISTRAR NOV 6 1967		25b. REGISTRAR'S SIGNATURE J. J. J.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH			
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beethesda</u>		c. LENGTH OF STAY IN 1b <u>52 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>10101 Gary Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Ida</u> First <u>m Henderson</u> Middle <u>m</u> Last <u>Henderson</u>				4 DATE OF DEATH <u>Nov. 27</u> 19 <u>67</u> Month <u>Nov</u> Day <u>27</u> Year <u>1967</u>			
5 SEX <u>m.</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/18/86</u>	9 AGE (In years last birthday) <u>82</u> yrs	10 F UNDER 1 YEAR Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min. <u>27</u>		11 F UNDER 24 HRS Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min. <u>27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert Richardson</u>			14. MOTHER'S MAIDEN NAME <u>Celia J. Van Wagoner</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16 SOCIAL SECURITY NO <u>364-07-0290</u>		17 INFORMANT <u>Kathleen Hart</u> Address <u>same as above</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. 332x IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO <u>Cerebral arteriosclerosis + Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral + general arteriosclerosis</u> (c) <u>Cerebral + general arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>24 hrs</u> <u>10 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>3. Hip - (Lk.) - severe osteoarthritis - debridement</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/1/66</u> to <u>11/27/67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11:27</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Stephen H. Jones M.D.</u>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen H. Jones</u>				22d. ADDRESS <u>Box 1195 Washington, Michigan</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1 Dec 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Albion Michigan</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Box 1195 Washington, Michigan</u>				DATE <u>NOV 29 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15612

15667

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Kings</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>23 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>454 - 76th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Roland Cortright Henning</u>				4 DATE OF DEATH Month Day Year <u>November 14 1967</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 June 1907</u>		9 AGE (In years last birthday) <u>60</u> yrs	IF UNDER 1 Year Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant Seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant Marines</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ulysses Henning</u>				14. MOTHER'S MAIDEN NAME <u>Emma Ackley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>157-03-3946</u>		17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebral infarction</u> DUE TO (c) <u>Rheumatic valvular heart disease</u>						INTERVA. BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 days</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>21 days following aortic valve replacement</u>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>xx</u> (this hospital) attended the deceased from <u>22 October, 1967</u> to <u>14 Nov.</u> , 1967, that <u>xx</u> (we) last saw the deceased alive on <u>14 November 1967</u> , and that death occurred at <u>1:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Eric H. Johnson</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1967</u> <u>14 November</u>	
22c. PHYSICIAN'S NAME (Type) <u>Eric H. Johnson, MD</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Brooklyn, New York</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



15813

CERTIFICATE OF DEATH

15608

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>New Bern</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. LENGTH OF STAY IN 1b <u>68 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Bern</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>				d. STREET ADDRESS <u>402 Garner Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Jean</u> Last <u>HILL</u>				4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1967</u> 19			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1930</u>		9. AGE (In years last birthday) <u>37</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Henry Burke</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Records</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>Sept 17</u> , 19 <u>67</u> , to <u>Nov 24</u> , 19 <u>67</u> , that <u>he</u> (we) last saw the deceased alive on <u>Nov 24</u> , 19 <u>67</u> , and that death occurred at <u>1245</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Ross B. Moquin</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>24 November 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Cdr R. B. Moquin, USN</u>				22d. ADDRESS <u>Naval Hospital, Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>New Bern North Carolina</u>	
24. FUNERAL DIRECTOR <u>Arnold F. Turner</u> ADDRESS <u>Cunningham Funeral Home, Alexandria, Va.</u>				25a. REC'D BY REGISTRAR <u>NOV 29 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u> </u>	



CERTIFICATE OF DEATH

15609

15614

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>317 F Street, N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Leroy (None) Hill</u>		4 DATE OF DEATH Month Day Year <u>November 15, 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 November 1913</u> 9 AGE (In years last birthday) <u>54 yrs</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>
11 BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bennie Hill</u>		14 MOTHER'S MAIDEN NAME <u>Clara Lope</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>Not available</u>	
17. INFORMANT <u>The Medical Record,</u> <u>The Clinical Center, Bethesda, Maryland 20014</u>		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatoma (Malignant Hepatoma)</u> DUE TO (b) <u>1000</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>8 Months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 24, 1967</u> , to <u>Nov. 15, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 15, 1967</u> , and that death occurred at <u>11:10</u> , from causes and on the date stated above			
22a. SIGNATURE <u>H. Thomas Foley, M.D.</u>		22b DATE SIGNED <u>16 November 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. Thomas Foley, MD.</u>		22d ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>11-20-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	23d LOCATION (City or Town) (County) (State) <u>Suitland Md</u>
24. FUNERAL DIRECTOR <u>Frogger 389 R.F. can</u>		25a. RECEIVED BY REGISTRAR <u>NOV 22 1967</u> DATE	
25b REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

25615

15510

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 26 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		e. STREET ADDRESS 20 Manchester Place	
3 NAME OF DECEASED (Type or print) First: Donald Middle: Jay Last: Hillegas		4. DATE OF DEATH Month: November Day: 23 Year: 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH 1-31-11
9a. AGE (In years last birthday) 56 Y's		9b. FUNERAL YEAR Months: Days: Hours: Min.	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled		10b. KIND OF BUSINESS OR INDUSTRY Inspector	
13 FATHER'S NAME Albert Hillegas		11 BIRTHPLACE (County & State or foreign country) Pennsylvania	
14. MOTHER'S MAIDEN NAME Ada Faust		12 CITIZEN OF WHAT COUNTRY? America	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO unknown	
17 INFORMANT Patient's chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X DUE TO (b) Antimicrobial Disease (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 10-28-67, 19 to Nov 23, 1967 that (I) (we) lost saw the deceased alive on Nov 24 1967, and that death occurred at 4:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE Boris Rabin		22b. DATE SIGNED Nov 23, 1967	
22c. PHYSICIAN'S NAME (Type) BORIS RABIN		22d. ADDRESS 1019 University Blvd E and	
23a BURIAL CREMATON, REMOVAL (Specify) Burial		23b DATE THEREOF Nov. 27-1967	
23c NAME OF CEMETERY OR CREMATORY Greenwood		23d LOCATION (City or Town) (County) (State) Takoma Park D.C.	
24. FUNERAL DIRECTOR Arthur Waters		25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE Nov 27 1967	

15615

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN It <u>8 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>10019 KENFREW ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH C. HILLARY</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/15</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Defense</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Springfield, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rou C. Chanin</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Colvin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>yes</u>	
17. INFORMANT <u>Donald H. Hillery</u>		Address <u>10,019 Kentrew Rd. S.S.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Influenza - Pneumonia</u> DUE TO (b) <u>Perforation Esophagus</u> DUE TO (c) <u>Esophageal Rupture</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>10 days</u> <u>1 day</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Nov 4, 1967</u> , to <u>Nov 17, 1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Nov 17, 1967</u> , and that death occurred at <u>9:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John P. Haberlin M.D.</u>		22b. DATE SIGNED <u>11-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John P. Haberlin M.D.</u>		22d. ADDRESS <u>1015 Spring Street Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Springfield Massachusetts</u>	
24. FUNERAL DIRECTOR <u>Robert S. P. Miller Inc.</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>	
ADDRESS <u>8434 Georgia Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 8, and return them to the funeral director. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 8, 9, 13 & 14 in 6355 1-12/67 KK

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>5 Mo 19 days</u>		d. STREET ADDRESS <u>4503 CLEARFIELD RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>HAZEL</u> Middle <u>D.</u> Last <u>HIRE</u>		4 DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/16/1894</u>
9 AGE (In years and birthday) <u>73 yrs</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEAUTICIAN</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>INDIANA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James William Hackler</u>	
14. MOTHER'S MAIDEN NAME <u>NANCY FLETCHER Fortner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>313-12-2589A</u>		17 INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Wide spread metastatic carcinoma</u> DUE TO (c) <u>Carcinoma of breast</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> to <u>11-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-7</u> , 19 <u>67</u> and that death occurred at <u>4 P.M.</u> from causes and on the date stated above			
22a SIGNATURE <u>Richard P. Delaney</u> MD		22b DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard P. Delaney, MD</u>		22d. ADDRESS <u>432 Howard St. Silver Sp. Ind</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>11/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>
24 FUNERAL DIRECTOR <u>J. Wm. Lees Sons, 300 4th St. NE, Wash, DC</u>		25a REC'D BY REGISTRAR DATE <u>NOV 10 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15612



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY in lb <u>10</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Hospital Center</u>		d STREET ADDRESS <u>700 North Washington St.</u>	
3 NAME OF DECEASED (Type or print) <u>Edgar Jerome Hocutt</u>		4 DATE OF DEATH <u>Nov 11 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 4 1939</u>
9 AGE (In years last birthday) <u>28</u> yrs		10 FUND 1 YEAR <u>19</u> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Doctor N.H.</u>	
11 BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Edgar J. Hocutt, 11</u>		14 MOTHER'S MAIDEN NAME <u>Mary Cromartie</u>	
15 WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>Same as #2</u>	
17 INFORMANT <u>Maxine L. Hocutt</u>		Address <u>Same as #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Overdose, Morphine</u> <u>4701</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>poisonous injection of morphine</u>	
20c TIME OF INJURY Month, Day, Year <u>2</u> hour <u>00</u> min <u>20</u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>at work</u>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Metals</u>	20f (City or town) (County) (State) <u>Cherry Chase Montgomery, Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John B. Baker</u>		22 DATE SIGNED <u>11/18/67</u>	
EXAMINER'S NAME (Type) <u>John B. Baker</u>		22 DATE SIGNED <u>11/18/67</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b DATE THEREOF <u>11/10/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Lees Crematory</u>		23d LOCATION (City or town) (County) (State) <u>Washington D. C.</u>	
24 FUNERAL DIRECTOR <u>J. Wm. Lees Sons, 300 4th St., NE, Wash. DC</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c DATE <u>NOV 13 1967</u>	

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Greenbrier</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>19 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center</u>		d. STREET ADDRESS <u>(No street address)</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wilson Bernard Holliday</u>		4 DATE OF DEATH Month Day Year <u>November 18 19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 May 1914</u>
9 AGE (In years last birthday) <u>53 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min <u>53</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Steuart Holliday</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Brisinham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Not available</u>	
17. INFORMANT <u>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>456X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Wegener's Granulomatosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>30 October, 1967</u> to <u>18 November 67</u> that <u>X</u> (we) lost saw the deceased alive on <u>18 November 19 67</u> , and that death occurred at <u>3:50AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Glenn L. Melson, II</u>		22b. DATE SIGNED <u>11/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Glenn L. Melson, M. D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-21-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wallace Mem. Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Clintonville, W. Va.</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>William Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

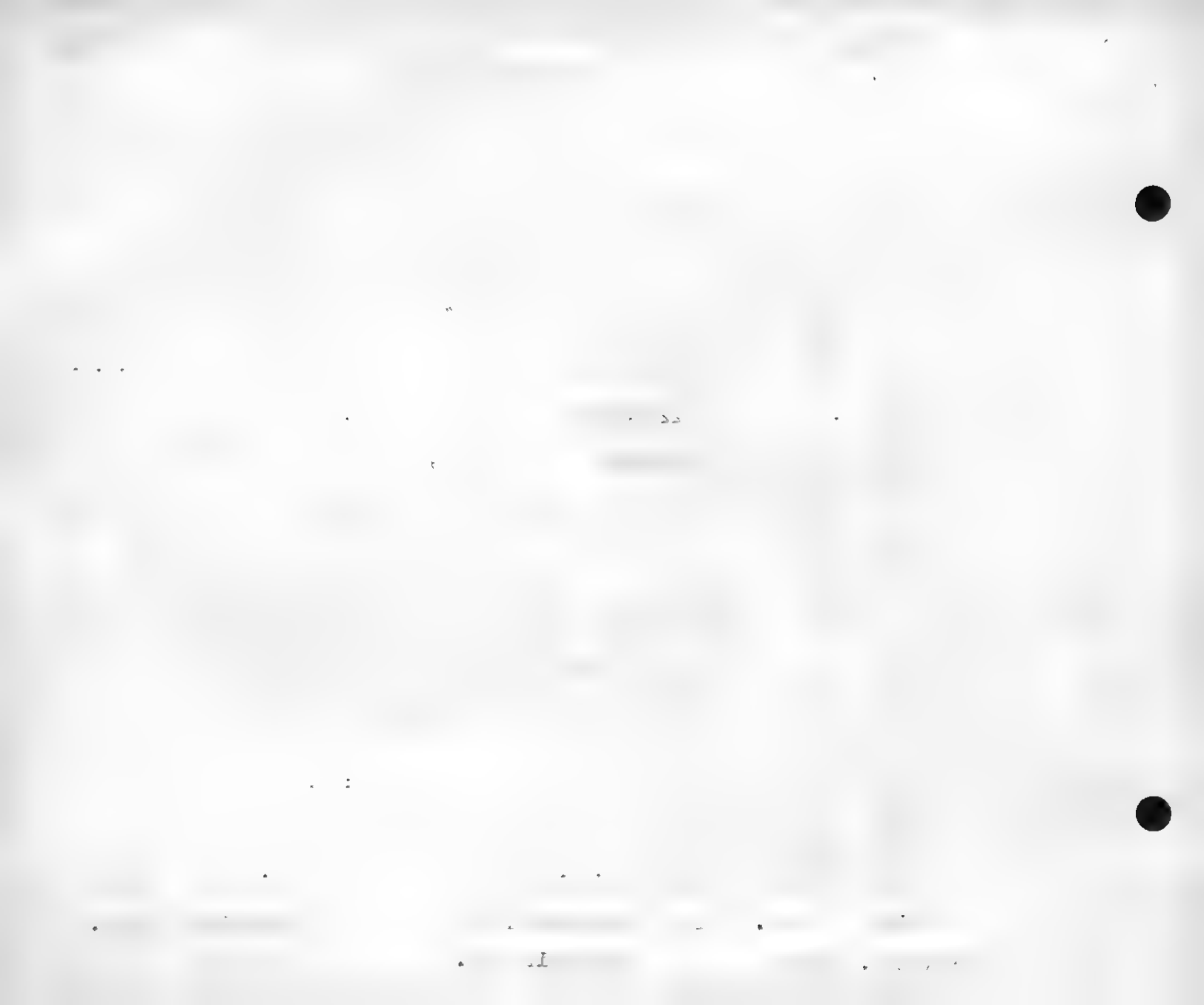
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 78 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Greeley Middle Golden Last Holston		4. DATE OF DEATH Month November Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/31
9. AGE (In years last birthday) 36 yrs		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 36 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) superintendent		10b. KIND OF BUSINESS OR INDUSTRY landscaping	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Estal W. Holston		14. MOTHER'S MAIDEN NAME Stella E. Musser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 44-1741-1111	
17. INFORMANT records, Montgomery General Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Liposarcoma, abdomen DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1967 to Nov. 21, 1967 , that (I) (we) last saw the deceased alive on Nov. 21, 1967 , and that death occurred at 5: P.M. from causes and on the date stated above.			
22a. SIGNATURE Frederick Moomau M.D.		22b. DATE SIGNED 11-21-67	
22c. PHYSICIAN'S NAME (Type) Frederick Moomau, M. D.		22d. ADDRESS Sandy Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 24 1967	23c. NAME OF CEMETERY OR CREMATORY Laytonsville	23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md.
24. FUNERAL DIRECTOR Francis H. Barber		25a. REC'D BY REGISTRAR NOV 27 1967	
25b. REGISTRAR'S SIGNATURE John Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

15621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i> c. LENGTH OF STAY IN 1b <i>14 DAYS</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>SUBURBAN</i>		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Mont</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i> d. STREET ADDRESS <i>5416 GLENWOOD RD</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <i>ALLEN</i> Middle <i>P</i> Last <i>HORN</i>		4 DATE OF DEATH Month <i>Nov.</i> Day <i>20</i> Year <i>1967</i>	
5 SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>8/22/88</i> 9 AGE (In years last birthday) <i>79</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Tennessee</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Lincoln S. Horn</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Pinkeaton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-44-0278</i> 17. INFORMANT <i>Helen - Wife - Same</i> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerotic heart disease</i> (c) <i>acute myocardial infarction</i> INTERVAL BETWEEN ONSET AND DEATH <i>year</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11-6</i> , 19 <i>67</i> , to <i>11-20</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>11-20</i> , 19 <i>67</i> , and that death occurred at <i>7:30 AM</i> , from causes and on the date stated above.			
22a SIGNATURE <i>Robert R. Montgomery</i> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>11-20-67</i>	
22c PHYSICIAN'S NAME (Type) <i>ROBERT R. MONTGOMERY</i>		22d ADDRESS <i>5411 CEDAR LANE BETHESDA, MD.</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE THEREOF <i>11-21-67</i>	23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	23d LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>
24 FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a REC'D BY REGISTRAR DATE <i>NOV 24 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15622 -

CERTIFICATE OF DEATH

15617

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN TB <u>5 days</u>				d. STREET ADDRESS <u>10102-Georgia Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hubert P. Hornsby</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1887</u>	9. AGE (In years, months, days, hours, minutes) <u>80</u> yrs	IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>67</u>		IF UNDER 24 HRS Days <u>19</u> Hours <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W.H. (U.S. Govt)</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOHN ALLEN HORNSBY</u>			
14. MOTHER'S MAIDEN NAME <u>EDITH PRIMM</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 1917-1919</u>			
16. SOCIAL SECURITY NO <u>549-01-9290-A</u>				17. INFORMANT Address <u>SILVER SPRING, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>4/7/67</u> to <u>4/8/67</u> , that (I) (we) last saw the deceased alive on <u>4/8/67</u> , and that death occurred at <u>1501 N. 1st St.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Curry</u>				22b. DATE'S GND <u>11/8/67</u>		22c. PHYSICIAN'S NAME (Type) <u>10620 Georgia Ave. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11-11-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	
23d. LOCATION (City or Town) <u>Silver Spring, Md.</u>				24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u>			
25a. REC'D BY REGISTRAR <u>NOV 13 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15623

15518

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Cleveland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>87 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>1165 East 60th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>(NMN)</u> Last <u>Horzen</u>		4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1904</u>
9. AGE (In years lost birthday) <u>63</u> yrs		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. BIRTHPLACE (County & State, or foreign country) <u>Yugoslavia</u>	
13. FATHER'S NAME <u>Joseph Vidonja</u>		14. MOTHER'S MAIDEN NAME <u>Maria Titan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hypertension</u> DUE TO (b) <u>Mitral Stenosis</u> DUE TO (c) <u>Rheumatic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post operative Starr-Edwards mitral valve replacement - 6 days</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <u>27 August</u> , 19 <u>67</u> , to <u>22 Nov.</u> , 19 <u>67</u> , that (X) (we) lost the deceased alive on <u>22 November</u> 19 <u>67</u> and that death occurred at <u>1:10 M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Eric H. Johnson</u>		22b. DATE SIGNED <u>22 Nov. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Eric H. Johnson</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cleveland, Ohio</u>
24. FUNERAL DIRECTOR <u>Wardner E. Pumphrey, Inc. Silver Spring, Md.</u>		25. REC'D BY REGISTRAR DATE <u>NOV 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15624

15619

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>	
c. LENGTH OF STAY IN 1b <u>12 hrs 46 min</u>		d. STREET ADDRESS <u>6645 Barnaby St. NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belhurburn</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>S.</u> Last <u>Hawell</u>		4 DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-4-95</u>
9 AGE (In years last birthday) <u>72 yrs</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Law- Corp of Engineers</u>		11 BIRTHPLACE (County & State, or foreign country) <u>TENN.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Dr J. J. Hawell</u>	
14. MOTHER'S MAIDEN NAME <u>LEMING</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWI</u>	
16 SOCIAL SECURITY NO. <u>Mr J. J. Hawell</u>		17 INFORMANT <u>Mrs J. J. Hawell - Abner</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> DUE TO (b) <u>Ruptured Abdominal Aneurysm</u> DUE TO (c) <u>1 day</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>95</u> to <u>11/29/67</u> , that (I) <u>two</u> saw the deceased alive on <u>11/29/67</u> , and that death occurred at <u>9:15</u> M, from causes and on the date stated above.	
22a SIGNATURE <u>Jay R. Shapiro</u> M.D.		22b DATE SIGNED <u>11/29/67</u>	
22c PHYSICIAN'S NAME (Type) <u>JAY R. SHAPIRO</u>		22d ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>12/4/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u>		23d LOCATION (City or town) (County) (State) <u>BLADENSBURG, MD.</u>	
24 FUNERAL DIRECTOR <u>Joseph Sauter</u> ADDRESS <u>512 15th Ave. N.W. Washington D.C.</u>		25a REC'D BY REG STRAR DATE <u>DEC 5 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



CERTIFICATE OF DEATH

15620

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>100 Deer Park Drive</u>		d. STREET ADDRESS <u>100 Deer Park Drive</u>	
3 NAME OF DECEASED (Type or print) <u>Robert H. Huff</u>		4 DATE OF DEATH Nov. 2, 1967	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 23, 1903</u>
9 AGE (In years, last birthday) <u>64</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>		11 BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert H. Huff, Sr.</u>	
14 MOTHER'S MAIDEN NAME <u>Victorina Jaffeau</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>0</u>		17 INFORMANT <u>Annie Lee Huff - wife</u> Address <u>same as dec'd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Metastatic Carcinoma lung</u> DUE TO (c) <u>Carcinoma of liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3mo.</u> <u>5mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>—</u> 19 <u>67</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f (City or town) (County) (State) <u>—</u>
21. I certify that (I) (this hospital) attended the deceased from <u>11/16</u> , 19 <u>67</u> , to <u>11/2</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>10/25</u> , 19 <u>67</u> , and that death occurred on <u>3 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>E. H. Aschenbach</u>		22b. DATE SIGNED <u>11/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernst H. Aschenbach</u>		22d. ADDRESS <u>1841 Columbia Rd., N.W., Wash., D.C.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11/4/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Heeler Funeral Home</u>		25a REC'D BY REGISTRAR DATE <u>NOV 3 1967</u>	
ADDRESS <u>1 Rock. Pike, Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15628

CERTIFICATE OF DEATH

15621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7 DALECARLIA ST.		d. STREET ADDRESS 7 Dalecarlia Street	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle E. Last Irwin		4. DATE OF DEATH Month 11 Day 6 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-1897
9. AGE (In years last birthday) yrs 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army Map	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marion English		14. MOTHER'S MAIDEN NAME N.C. Bowling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-28-3412	
17. INFORMANT Lottie Owens		Address Falmouth, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myelocytic Leukemia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from 8/10/1967 to 11/6/1967 , that (I) (we) last saw the deceased alive on 11/6/1967 , and that death occurred at 9:30 A.M. from causes and on the date stated above.	
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) M.D.		22d. ADDRESS ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-9-67	
23c. NAME OF CEMETERY OR CREMATORY ROCK HILL CEM.		23d. LOCATION (City or Town) _____ (County) _____ (State) _____	
24. FUNERAL DIRECTOR Robert A. Delf		25a. REC'D BY REGISTRAR Washington D.C.	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25c. DATE NOV 13 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

CLEARED WITH MEDICAL EXAMINER/med.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15627

CERTIFICATE OF DEATH

15622

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 911 Lamberton Drive	
3 NAME OF DECEASED (Type or print) First MORRIS Middle JACOBSON Last JACOBSON		4. DATE OF DEATH Month Nov. Day 23 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/07
9 AGE (In years last birthday) 59 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesmanager		10b. KIND OF BUSINESS OR INDUSTRY Laundry Equipment	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Louis Jacobson		14. MOTHER'S MAIDEN NAME Ida Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-01-6099	
17. INFORMANT David Jacobson (same as 2 above)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO (b) Coronary artery disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-11 , 19 52 , to 11-23 , 19 67 that (I) (we) last saw the deceased alive on 11-23 , 19 67 , and that death occurred at 4:21 P.M. from causes and on the date stated above.			
22a. SIGNATURE George J. Hageage		22b. DATE SIGNED 11-23 67	
22c. PHYSICIAN'S NAME (Type) George J. Hageage		22d. ADDRESS 3717 38th Ave. (off) City	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-26-1967	
23c. NAME OF CEMETERY OR CREMATORY Natl. Mem. Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th Street N.W.		25a. REC'D BY REGISTRAR NOV 27 1967	
		25b. REGISTRAR'S SIGNATURE W. J. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages (pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000).

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN It <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>					d. STREET ADDRESS <u>8912 Mohawk La</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Elizabeth Newcomb Janeck</u>					4. DATE OF DEATH <u>Nov 26 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/4/1874</u>		9. AGE (In years last birthday) <u>93</u> yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State or foreign country) <u>Lodi Wisconsin</u>			12. C. T. ZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John I. Newcomb</u>					14. MOTHER'S MAIDEN NAME <u>Delia S. Chusler</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>535-09-0143</u>		17. INFORMANT <u>Daughter</u>			Address <u>Same as Item 2.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Infarction, cerebrum, massive</u> DUE TO (b) <u>cerebral arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1954</u> to <u>NOV 1967</u> that (I) (we) just saw the deceased alive on <u>11/26 1967</u> , and that death occurred at <u>4:25</u> M, from causes on and on the date stated above.										
22a. SIGNATURE <u>[Signature]</u> M.D.					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED <u>11/26/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>DR LEO I DONOVAN</u>					22d. ADDRESS <u>8218 WISCAM BETHESDA</u>					
23a. BURIAL, CREMATION, <u>Cremation</u>			23b. DATE THEREOF <u>11-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			23d. LOCATION (City or town) (County) (State) <u>Suitland Fr. Geo Md</u>		
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u> ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>					25a. REC'D BY REGISTRAR <u>DEC 4 1967</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>Rt #1 Box 265A</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Ethel</u> Middle <u>Mae</u> Last <u>Johnson</u>		4. DATE OF DEATH		Month <u>November</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 6, 1967</u>		9. AGE (in years last birthday) yrs. <u>7</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Guy Lester Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Thomasine Wilson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Mother</u>		Address <u>as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>1133</u> DUE TO (b) <u>fracture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 6</u> , 19 <u>67</u> , to <u>Nov 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 7</u> , 19 <u>67</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Morris Feitel</u>						22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>MORRIS FEITEL MD</u>				22d. ADDRESS <u>704 Gorman Ave LAUREL MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<u>Burial</u>		<u>11/10/67</u>		<u>Get. of Annapolis Cemetery Silver Spring, Md.</u>					
24. FUNERAL DIRECTOR <u>Pyson Wheeler Funeral Home</u>				ADDRESS <u>1331 Rock Pike Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
GM 1/67

<div>Items 10-21 Film 396 12-2 MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>15630 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15625</div>											
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital						d. STREET ADDRESS 10324 Greenock Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Morris Edward Johnson						4 DATE OF DEATH Month 11 Day 16 Year 67					
5 SEX Male		6. COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/29/07		9 AGE (In years last birthday) 59 yrs		IF UNDER 1 YEAR Months Days hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Accountant-Supervisor Wash Gasolt Co				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Albert A. Johnson						14 MOTHER'S MAIDEN NAME Eva Bunch					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO 577-07-7386		17 INFORMANT Silver Spring, Maryland Alida Johnson 10204 Greenock Road					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 904.0 DUE TO Acute pulmonary embolization accompanied by acute subdural hematoma and Leptomenigitis Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Deceased fell at home before hospitalization, striking head							
20c. TIME OF INJURY Month Day Year Hour a.m. xx 10-18 1967				20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm factory street office bldg, etc) Home		20f. (City or town) (County) (State) Silver Spring Montg. Md.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED Nov. 18, 1967			
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 20, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION (City or town) (County) (State) Prince Geo. County, Md.			
24. FUNERAL DIRECTOR Warner E. Purphrey, Inc. 8434 Ga. Ave.						25a. REC'D BY REGISTRAR NOV 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

15326

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN TB WASHINGTON D.C.		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		d. STREET ADDRESS 7036 EASTERN AVE. N.W.	
3 NAME OF DECEASED (Type or print) CHARLES H. JONES		4 DATE OF DEATH Month 11 Day 11 Year 1967	
5 SEX M	6 COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-29-18
9 AGE (In years last birthday) 49 yrs.		10 UNDER 1 YEAR Months 11 Days 11 Hours 11 Min 11	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELDERMAN		10b KIND OF BUSINESS OR INDUSTRY ELDERMAN	
11 BIRTHPLACE (County & State, or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME McKisley Jones		14. MOTHER'S MAIDEN NAME Nettie Stewart	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1942 to 1943		16. SOCIAL SECURITY NO. 1942 to 1943	
17. INFORMANT Betty C. Jones - wife		Address Betty C. Jones - wife	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1810 IMMEDIATE CAUSE (a) Pulmonary metastasis DUE TO (b) Carcinoma of Bladder DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 145	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1966 to April 1967 that (I) was last saw the deceased alive on 11/10 19 67 , and that death occurred at 5:4 M, from causes on and on the date stated above			
22a SIGNATURE J. Howard Jones		22b. DATE SIGNED 11/11/67	
22c. PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11-15-67	
23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d LOCATION (City or Town) (County) (State) Suitland, Maryland	
24 FUNERAL DIRECTOR John T. R. Jones Co		25a REC'D BY REGISTRAR NOV 17 1967	
25b REGISTRAR'S SIGNATURE John T. R. Jones		25c REGISTRAR'S SIGNATURE John T. R. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



15632

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15527

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Howard ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c LENGTH OF STAY IN 1b 28 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e STREET ADDRESS Jennings Chapel Road	
3. NAME OF DECEASED (Type or print) First Martha Middle Randall Last Jones		4. DATE OF DEATH Month November Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/19
9. AGE (In years birthday) yrs 48		10. UNDER 1 YEAR Months Days Hours Min F UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Univ. of Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis R. Randall		14. MOTHER'S MAIDEN NAME Martha Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Medical Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARCINOMA, BRONCHOGENIC, RLL DUE TO (b) CARCINOMA, METASTATIC, LYMPH NODES, LIVER, BRAIN DUE TO (c) PULMONARY FIBROSIS, RT. LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PULMONARY EDEMA, DIVERTICULOSIS			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY , 19 67 , to Nov. 7 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 6 , 19 67 , and that death occurred at 9:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		22d. ADDRESS Clarksville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11-10-67	23c. NAME OF CEMETERY OR CREMATORY St. Louis Cemetery	23d. LOCATION (City or Town) (County) (State) Clarksville, Md.
24. FUNERAL DIRECTOR Harry Wm Knight Sykesworth, Md.		25a. REC'D BY REGISTRAR. DATE NOV 10 1967	
		25b. REGISTRAR'S SIGNATURE Charles Jones	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15632

15628

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>28 Richie Avenue</u>			
3 NAME OF DECEASED (Type or print) <u>Lee Andrew Jordan JR.</u>				4 DATE OF DEATH <u>November 13 1967</u>			
5 SEX <u>MALE</u>		6. COLOR OR RACE <u>Negro</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1936</u>	
9 AGE (In years last birthday) <u>31</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
13 FATHER'S NAME <u>Lee A. Jordan SR.</u>				14 MOTHER'S MAIDEN NAME <u>Helen MAY WARREN</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO		17 INFORMANT <u>Lee</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1160</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) <u>Conflagration Burns of over 90% of body surface</u> DUE TO (c) <u>incurred in house fire</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased burned in house fire</u>			
20c. TIME OF INJURY Month, Day, Year <u>248</u> <u>11-13-67</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc) <u>HOME</u>	
20f. (City or town) <u>Takoma Park</u>				20g. (County) <u>Montgomery</u>		20h. (State) <u>MD.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Read, M.D.</u>				22 DATE SIGNED <u>Nov. 13, 1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. READ, M.D.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
23b. DATE THEREOF <u>Nov. 16, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>			
23d. LOCATION (City or Town) <u>SANDY SPRING</u>				23e. (County) <u>Montgomery</u>			
23f. (State) <u>MD.</u>				25a. REC'D BY REGISTRAR <u>NOV 21 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Robert L. Snowden</u>				25c. REGISTRAR'S NAME <u>Rockville, Md.</u>			



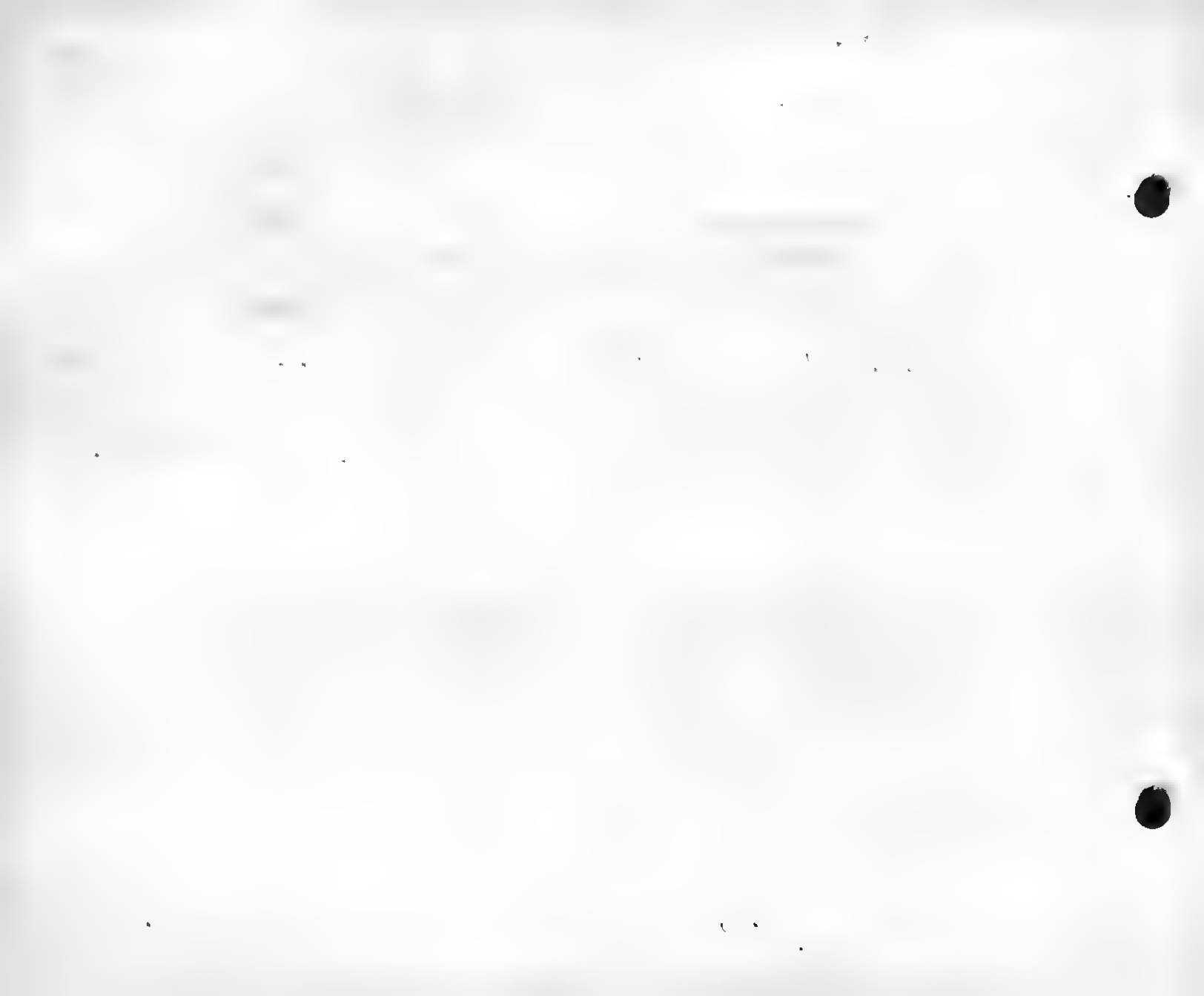
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

-closed with burial permit

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
15634											
15629											
1 PLACE OF DEATH a COUNTY Montgomery MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b COUNTY Montgomery STATE M Maryland					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillandale				c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Maryland					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital						d STREET ADDRESS 311 Burnt Mills XXXXX Ave				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Thomas First Middle Last Ward Joy						4 DATE OF DEATH Month Nov. Day 4 Year 1967					
5 SEX M		6 COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 28 November, '89		9 AGE (in years last birthday) 77 yrs		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min 11	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Govt				10b KIND OF BUSINESS OR INDUSTRY Retired		11 BIRTHPLACE (County & State, or foreign country) Washington, D.C.			12 CITIZEN OF WHAT COUNTRY? USA		
13 FATHER'S NAME Bernard F. Joy						14 MOTHER'S MAIDEN NAME Harriet Ward					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO				16 SOCIAL SECURITY NO		17 INFORMANT Address Mrs Beatrice P. Joy (Same as # 20.)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										INTERVAL BETWEEN ONSET AND DEATH 1 hr. 15 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from 10/2/65 to 11/4/67 , that (I) (we) last saw the deceased alive on 11/4/67 , and that death occurred at 11:30 PM from causes and on the date stated above.											
22a SIGNATURE John J. Curry						22b DATE SIGNED 11/4/67					
22c PHYSICIAN'S NAME (Type) John J. Curry						22d ADDRESS 10620 Georgia Ave					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Nov. 8, 67		23c NAME OF CEMETERY OR CREMATORY Rock Creek Cem				23d LOCATION (City or town) (County) (State) Washington, D.C.			
24 FUNERAL DIRECTOR W. B. Huntemann & Son						25a REC'D BY REGISTRAR DATE NOV 9 1967		25b REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

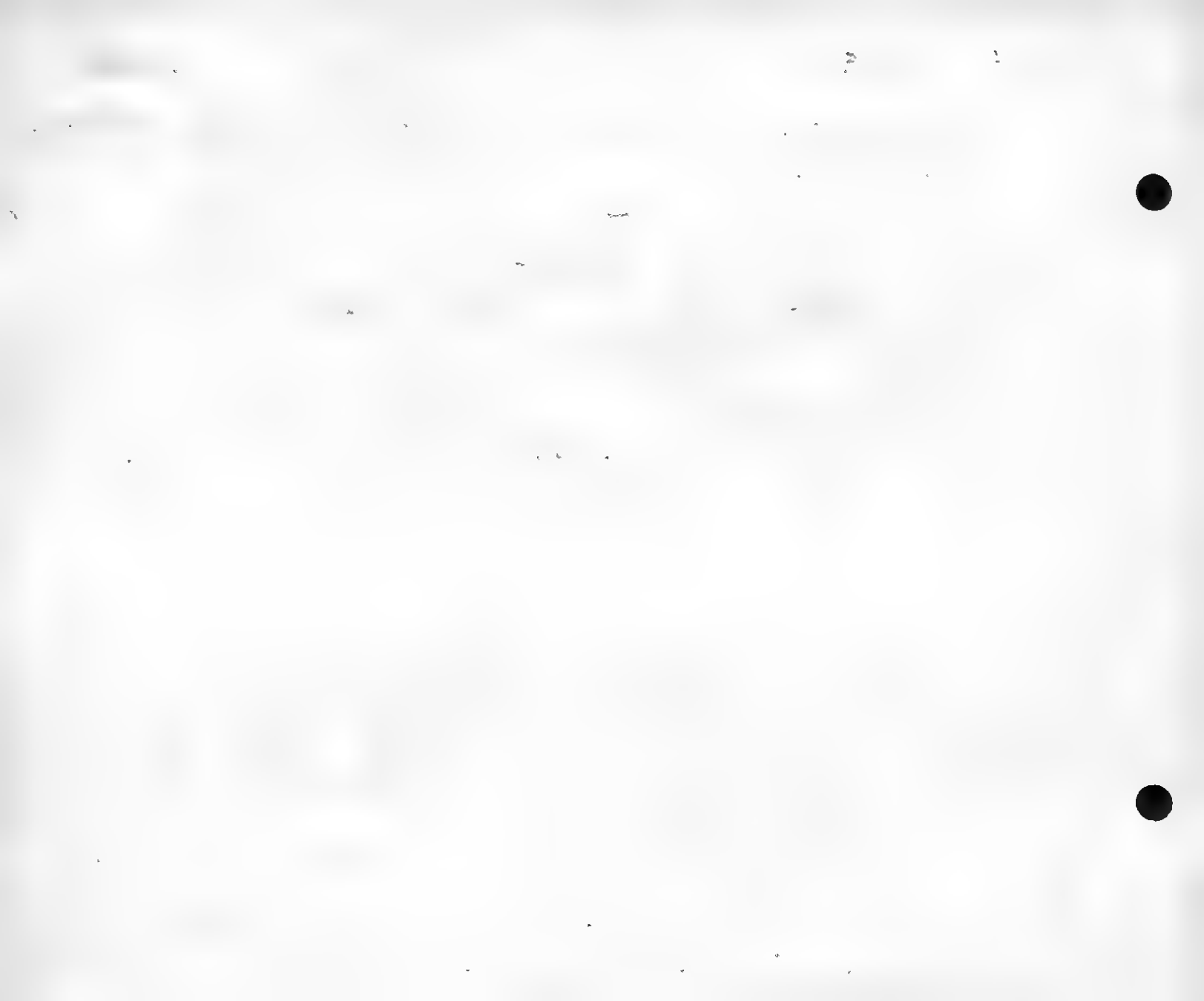
VR A15ME (5)
6M 1/67

Items 18-20 Film 395
11-20-67 am
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15630

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY in 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. & HOSP.		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BELTSVILLE d. STREET ADDRESS 4303 ELWOOD ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) KATHLEEN HARRIET KALEYIAS		4 DATE OF DEATH Month NOVEMBER Day 2 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JULY 12, 1946
9 AGE (In years last birthday) 21		10 IF UNDER 1 YEAR Months 2 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY UNIV. MD.	
11 BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME SPIROS KALEYIAS		14 MOTHER'S MAIDEN NAME MARY HARRIS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 216-54-5171	
17 INFORMANT Spiros Kaleyias		Address 4303 Elmwood Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple extreme injuries including DUE TO severance of cervical spinal cord incurred (b) in auto accident DUE TO in auto accident (c) in auto accident			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION (Even in Part I)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Deceased was driver of auto which crossed midline and collided with oncoming car.	
20c. TIME OF INJURY Month Day Year 9:05 pm 11-2 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Street		20f. (City or town) (County) (State) Beltsville Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Read M.D.		22. DATE SIGNED Nov. 3, 1967	
EXAMINER'S NAME (Type) BELDEN R. READ M.D.		23. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF November 6, '67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or town) (County) (State) Prince Georges Maryland
24. FUNERAL DIRECTOR C. Glen Carter		25a. REC'D BY REGISTRAR NOV 8 1967	
Warner E. Pumphrey Inc. 8434 Georgia Ave. SS		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15631

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Box 36</u>	
3. NAME OF DECEASED (Type or print) <u>Patrick Anthony Karnes</u>		4. DATE OF DEATH <u>Nov. 14 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/52</u> 13 yrs
9. AGE (in years last birthday) <u>15</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Patrick Karnes</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Mc Glynn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>parents / same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Skull fracture</u> DUE TO (b) <u>automobile accident</u> DUE TO (c) <u>lost.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year <u>7 pm Nov 14 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <u>17 S 1700 W St.</u>		20f. (City or town) (County) (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John H. Ball</u> M.D.		22. DATE SIGNED <u>Nov 17 1967</u>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	23d. LOCATION (City or town) (County) (State) <u>Barnesville Mont. Md.</u>
24. FUNERAL DIRECTOR <u>William C. Hutter, Barnesville, Md.</u>		25a. REC'D BY REGISTRAR <u>William C. Judge</u> 25b. REGISTRAR'S SIGNATURE	
DATE <u>NOV 20 1967</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15637

15632

1. PLACE OF DEATH a COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN 15 Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 9920 Georgia Ave., Apt. #3	
3. NAME OF DECEASED (Type or print) First PEARL Middle D. Last KASOFSKY		4. DATE OF DEATH Month Nov. Day 10 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1899
9. AGE (In years birthday) yrs 68		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Jewelry	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Issac Aurbach		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) 0		16. SOCIAL SECURITY NO 577-05-9909	
17. INFORMANT (Son) Silver Spring, Md. Jack Kasofsky - Caddington St.,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Essential Hypertension - Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above. Held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Keap M.D.		22. DATE SIGNED Nov. 11, 1967	
EXAMINER'S NAME (Type) BELDEN R. KEAP, M.D.		Address (City, State, County) Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-12-1967	23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery	23d. LOCATION (City or town) (County) (State) Hyattsville, Md.
24. FUNERAL DIRECTOR Good Shepherd Home		25a. REC'D BY REG. STRAR NOV 13 1967	
ADDRESS 4214 14th St NW		25b. REGISTRAR'S SIGNATURE Charles Judge	



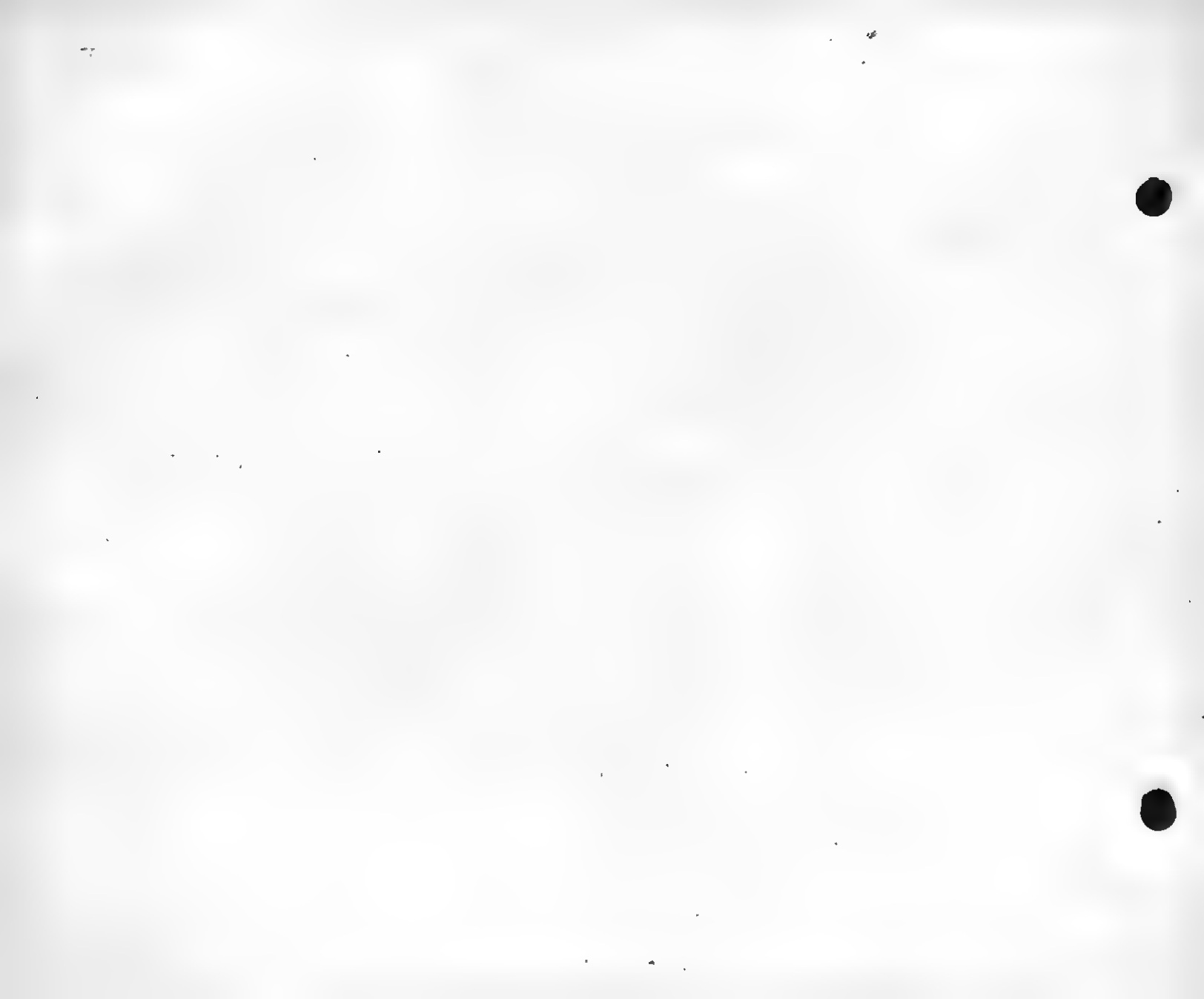
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 yrs 3 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8301 16th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Aguiinas Keelan</u>			4. DATE OF DEATH Month Day Year <u>Nov 16 1967</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15 1892</u>	9. AGE (In years last birthday) <u>75</u> yrs.	10. FUNERAL YEAR <u>1967</u> HRS. <u>16</u> MIN. <u>16</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Company</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>			
13. FATHER'S NAME <u>Thomas Keelan</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Leonard</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>1917-1918</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Dr. Thomas Keelan Jr. Tenley Bldg. Rockville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>442X</u> DUE TO <u>Cerebral Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO <u>hypertension</u> (c) <u>sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>3 years</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1967</u> to <u>16 Nov 1967</u> that (I) (we) last saw the deceased alive on <u>Nov 1967</u> and that death occurred at <u>1200</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Robert C. Haile</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/16/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Haile</u>		22d. ADDRESS <u>35 N.Y. Ave. N.W. Wash. D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>Nov 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>			
23d. LOCATION (City, town or county) (State) <u>Wheaton, Md.</u>		24. FUNERAL DIRECTOR <u>Joseph GAWLERS SONS 5730 WISC. AVE. NW WASH. D.C.</u>					
25a. REC'D BY REGISTRAR <u>Nov 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

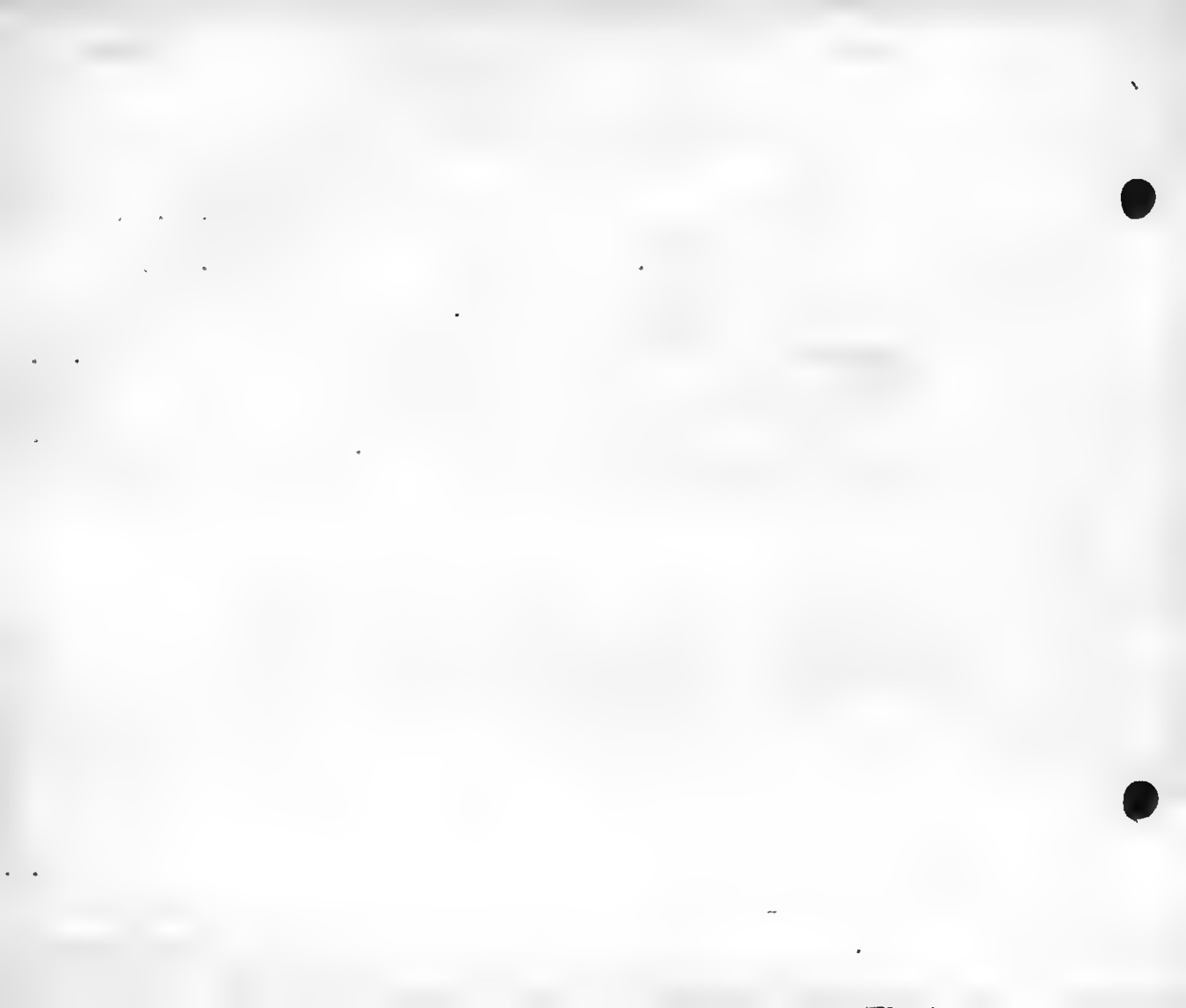
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15633

15634

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN It 8 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resmor Hospital		d. STREET ADDRESS 3212 Macomb Street, N. W.	
3 NAME OF DECEASED (Type or print) Alice M. KEITH.		4 DATE OF DEATH Month Nov. Day 27, Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 2, 1872
9 AGE (In years lost birthday) yrs 95		IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Ohio		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Herman Munhall		14. MOTHER'S MAIDEN NAME Mary Piper	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Nathaniel S. Keith		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: MED-ATE CAUSE (a) ARTERIO SCLEROSIS - DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 10 yr +
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Sclerosis -			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that (i) (this hospital) attended the deceased from 1935 to 11-27- 1967 , that (i) (we) last saw the deceased alive on 11-27-67 19 , and that death occurred at 5:45 PM from causes on and on the date stated above.			
22a. SIGNATURE Wynne M. Baker		22b. DATE SIGNED 11-27-67	
22c. PHYSICIAN'S NAME (Type) WYRTH POST BAKER		22d. ADDRESS 1635 HARVARD ST. N.W. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVA. (Specify) Cremation	23b. DATE THEREOF 11-28-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 4 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

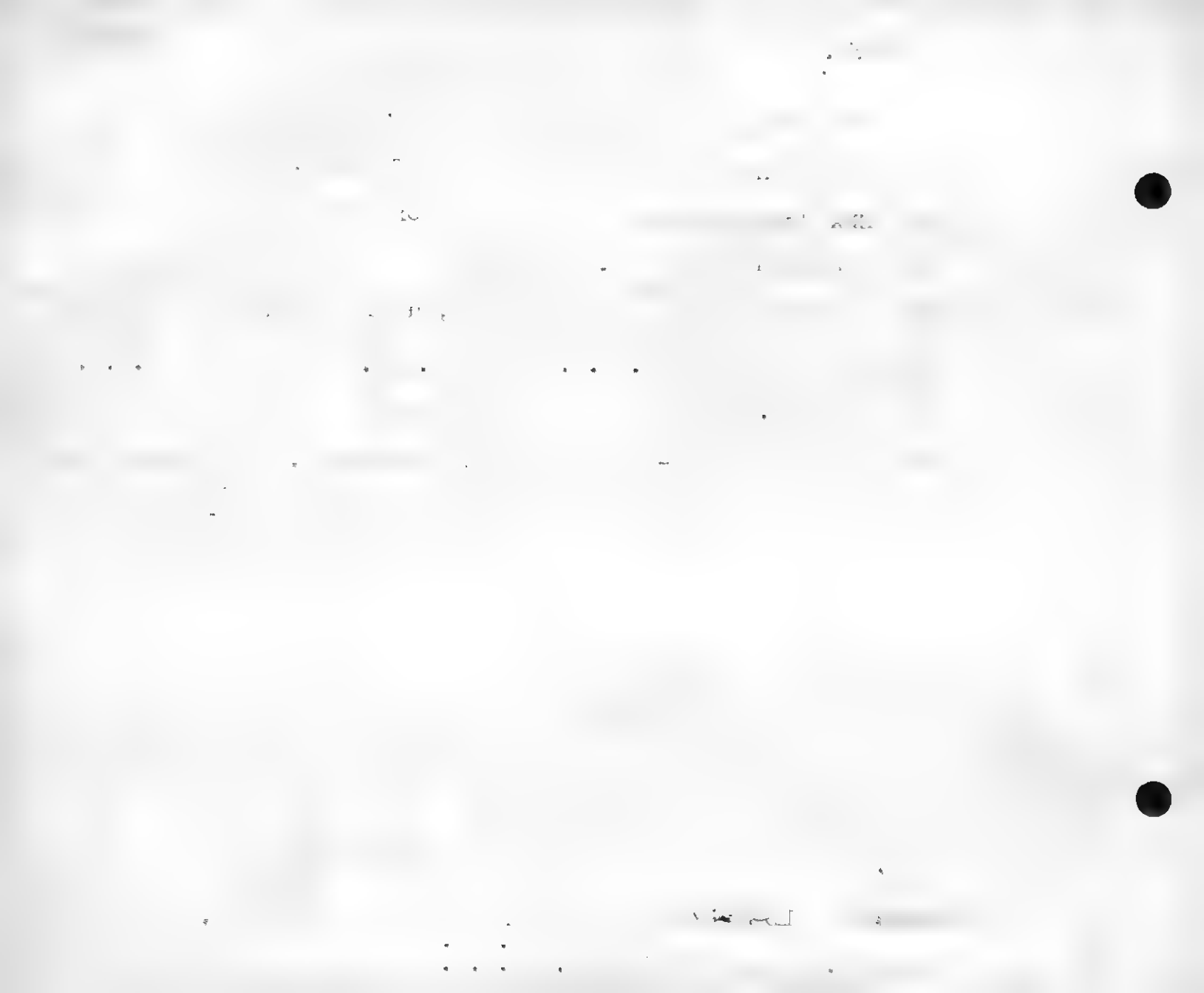


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Ohio b. COUNTY Trinway ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy XXX Cross Hospital		d. STREET ADDRESS Box 214	
3 NAME OF DECEASED (Type or print) Sheldon A. Keith		4 DATE OF DEATH Month 28 , Nov, 67 Year 19	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 14, Aug, 92
9 AGE (in years lost birthday) yrs 75		10 UNDER 1 YEAR IF UNDER 24 HRS Months 7 Days 14 Hours 14 Min 14	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b KIND OF BUSINESS OR INDUSTRY PENN. R.R.	
11 BIRTHPLACE (State or foreign country) W. VA.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME LEWIS E. KEITH		14 MOTHER'S MAIDEN NAME ELVA MAY ALEXANDER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. A-888043	
17 INFORMANT MRS. GERTRUDE W. KEITH		Address Same as #12	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Coronary Artery Heart Disease DUE TO (c) Coronary Artery Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 12	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o m p.m. 19		20d INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above and an Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE Belden R. Keap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED Nov. 28, 1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (If not in city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11-22-67	
23c NAME OF CEMETERY OR CREMATORY DRESDEN CEMETERY		23d LOCATION (City or Town) (County) (State) DRESDEN, OHIO	
24 FUNERAL DIRECTOR Francis J. Collins		ADDRESS WASH. D.C.	
25a REC'D BY REGISTRAR DEC 1 1967		25b REGISTRAR'S SIGNATURE Francis J. Collins	



CERTIFICATE OF DEATH

15641

15636

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Pennsylvania b COUNTY ✓		
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN 1b 61 days	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Mill Hall		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland			d STREET ADDRESS 6 Pennsylvania Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Marjorie Jane Kessinger			4 DATE OF DEATH Month Day Year November 8 1967		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 28, 1927	9 AGE (in years last birthday) yrs 40	IF UNDER 1 Year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (County & State or foreign country) Pennsylvania	
13. FATHER'S NAME J. Russell Gallagher			14. MOTHER'S MAIDEN NAME Florence Hoffard		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 190-22-1426		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Lymphosarcoma, generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laryngeal obstruction due to lymphosarcoma DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 9 years 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory street office bldg, etc.)	20f (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 8, 1967 , to Nov. 8, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 8, 1967 , and that death occurred at 6:00 AM , from causes and on the date stated above.					
22a SIGNATURE <i>Bruce A. Chabner</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED 8 November 1967	
22c PHYSICIAN'S NAME (Type) Bruce A. Chabner, M.D.		22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/11/67	23c NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d LOCATION (City or Town) (County) (State) Jock Haven, Pennsylvania	
24 FUNERAL DIRECTOR Tyson Wheeler		ADDRESS 1331 Rockville Pike Rockville, Maryland		25a. REC'D BY REGISTRAR DATE NOV 10 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15642-

15637

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b CITY OR TOWN (If outside corporate limits, write BUREAU and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>4 mos. + 24 days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>				d STREET ADDRESS <u>1310 Chillum Rd.</u>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Raymond Homer Kidwell</u>				4 DATE OF DEATH Month <u>11</u> - Day <u>10</u> - Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>Wh</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-10-15</u>		9 AGE (In years lost birthday) <u>52</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Fetterman Hardware</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Wash D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Raymond Q. Kidwell</u>				14 MOTHER'S MAIDEN NAME <u>Estelle Hamack</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>225-05-0582</u>		17 INFORMANT <u>Hospital record</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Carcinoma prostate</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9-10 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Feb</u> , 1967, to <u>Nov 11</u> , 1967, that (I) <u>(was)</u> last saw the deceased alive on <u>Nov 11</u> , 1967, and that death occurred at <u>3:55 PM</u> , from causes and on the date stated above							
22a SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-10-67</u>	
22c PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>				22d ADDRESS <u>11161 New Hampshire Ave S.E.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>11/13/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier Maryland</u>		25a REC'D BY REGISTRAR DATE <u>NOV 15 1967</u>	
						25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>118 Normandy Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Louise</u> Last <u>Kinchebe</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 22-1906</u> 60 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BRISTOL TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM FRANK SMITH</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Morgan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>408-32-6354</u>	
17. INFORMANT <u>Lyle M Kinchebe</u> (husband) Address <u>(Same)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Multiple Metastases from Breast</u> (c) <u>12 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes - Previous Coma</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State) <u>DOA</u> <u>UP</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>On 11/12, 1967</u> , to <u>DOA</u> , that (I) (we) last saw the deceased alive on <u>11-1</u> <u>1967</u> , and that death occurred at <u>6 A M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rich. L. Riddick</u>		22b. DATE SIGNED <u>11-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rich. L. Riddick</u>		22d. ADDRESS <u>1835 Eye St. N W Wash DC</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>Nov. 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u>
24. FUNERAL DIRECTOR <u>Glen Carter</u>		25a. ADDRESS <u>8434 Georgia Avenue</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
25. DATE <u>NOV 17 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION
I have verified and approved the above



CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>2 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e STREET ADDRESS <u>7801 Hamilton Spring Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Theodor Knudsen</u>		4 DATE OF DEATH Month <u>Nov</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>m.</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/24/1889</u>
9a AGE (in years last birthday) <u>78</u>		9b IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u> Hours <u>67</u> Min <u>78</u>	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Business</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Business</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Peter Knudsen</u>		14 MOTHER'S MAIDEN NAME <u>Katherine Lorenzen</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17 INFORMANT <u>Paula Knudsen</u>		Address <u>above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction recent and remote</u> DUE TO (b) <u>coronary thrombosis and arteriosclerosis</u> DUE TO (c) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 14</u> , 19 <u>67</u> to <u>Nov. 16</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>11/16</u> 19 <u>67</u> , and that death occurred at <u>4:30</u> P.M. from causes and on the date stated above.			
22a SIGNATURE <u>Ronald Barr, M.D.</u>		22b DATE SIGNED <u>11/17/67</u>	
22c PHYSICIAN'S NAME (Type) <u>RONALD BARR</u>		22d ADDRESS <u>1641 E. CORRECTION RD. BETHESDA MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>11/18/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>FORTHGREEN CEMETERY</u>	23d LOCATION (City or Town) (County) (State) <u>ELGAR MARY MD</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, Inc</u>		25a REC'D BY REGISTRAR <u>NOV 20 1967</u>	
ADDRESS <u>SILVER SPRING MD</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



15645

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>35 YRS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11508 OREDAUGH AVE</u>		d. STREET ADDRESS <u>2922 ELLICOTT TERR. N.W.</u>	
3 NAME OF DECEASED (Type or print) <u>SAMUEL</u> First Middle Last <u>KULCHINSKY</u>		4 DATE OF DEATH Month <u>NOV.</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 12, 1887</u>
9. AGE (in years last birthday) <u>80</u> yrs		10. F UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCER</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>HARRY KULCHINSKY</u>		14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv cel) <u>NO</u>		16 SOCIAL SECURITY NO <u>219-32-1319</u>	
17 INFORMANT <u>R. HARRY KULLEN</u>		18 ADDRESS <u>3600 WOODVALLEY DRIVE</u>	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>5 YEARS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (th's hospital) attended the deceased from <u>NOV. 14</u> , 19 <u>67</u> , to <u>NOV. 15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>NOV. 14</u> , 19 <u>67</u> , and that death occurred at <u>4:45</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>SAUL ZUKERMAN MD</u>		22b. DATE SIGNED <u>11-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAUL ZUKERMAN, MD</u>		22d. ADDRESS <u>5410 CONNECTICUT AVE WASHINGTON, D.C.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETH EL MEMORIAL PARK</u>	23d. LOCATION (City or town) (County) (State) <u>RANDALLSTOWN, MD.</u>
24 FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC.</u>		25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>SOL LEVINSON</u>		25c. REGISTRAR'S SIGNATURE <u>SOL LEVINSON</u>	

CERTIFICATE OF DEATH

15641

15646

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c LENGTH OF STAY IN 1b Washington d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Dist. of Col. b COUNTY Washington c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d STREET ADDRESS 4517 43rd Place, N.W. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) GERARD L. KYLE		4 DATE OF DEATH Month 11 Day 26 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-3-1901
9 AGE (In years last birthday) 66 Yrs		10 IF UNDER 1 YEAR Months 6 Days 26 Hours 19 Min 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer - Retired		10b KIND OF BUSINESS OR INDUSTRY Gov't. Printing	
11 BIRTHPLACE (County & State, or foreign country) Massachusetts		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME John Kyle		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - - - -		16 SOCIAL SECURITY NO - - - - -	
17 INFORMANT Julia M. Kyle - Wife - See Item No. 2.		Address - - - - -	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Emphysema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Chronic congestive heart failure DUE TO Arteriosclerotic Heart Disease (c) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH years year years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/22/67 to 11/26/67 , that (I) (we) last saw the deceased alive on 11/26/67 , and that death occurred at 12:00 AM from causes and on the date stated above			
22a SIGNATURE John J. Curry		22b DATE SIGNED 11/26/67	
22c PHYSICIAN'S NAME (Type) John J. Curry		22d ADDRESS 11620 Georgia Ave. Silver Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11-29-1967	
23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24 FUNERAL DIRECTOR Joe Goulers Sons		25a REC'D BY REGISTRAR 5130 WISC. AVE NW WASH. D.C.	
25b REGISTRAR'S SIGNATURE Charles J. Jones		DATE DEC 4 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>	
c. LENGTH OF STAY IN Tb <u>9 hrs.</u>		d. STREET ADDRESS <u>728 HARRINGTON RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>BABY STACIS ELIZABETH LEA</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov 11, 1967</u>
9 AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>BETHESDA, MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ELLIS LEA JR.</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA FINN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17 INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Erythroblastosis fetalis</u> <u>7705</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Prematurity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 1967, to <u>11/11</u> , 1967, that (I) (we) last saw the deceased alive on <u>11/11</u> 1967, and that death occurred at <u>2:20 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Moises Steren</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MOISES STEREN</u>		22d. ADDRESS <u>1111 Diamondston Ave., Rockville, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Funeral Home</u>		25a. REC'D BY REG STRAR DATE <u>NOV 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15048		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		15643	
CERTIFICATE OF DEATH					
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>30 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>10823 Georgia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>V.</u> Last <u>Leslie</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1967</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/08</u>	9. AGE (in years last birthday) <u>59</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Crucifix, Wisconsin</u>	
13. FATHER'S NAME <u>WILLIAM GILBERT</u>			14. MOTHER'S MAIDEN NAME <u>CHARLOTTA MATTHIESSEN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>135-26-228</u>		17. INFORMANT <u>Husband, Arnold Leslie</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Undifferentiated carcinoma, stomach, (linitis plastica)</u> 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 11, 1967</u> , to <u>Nov. 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/20 1967</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above					
22a. SIGNATURE <u>Frederick Y. Donn</u>			22b. DATE SIGNED <u>11/21/1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK Y. DONN</u>			22d. ADDRESS <u>10400 Conn. Ave. - Kensington, MD</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>11/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lincoln Crematory</u>		23d. LOCATION (City or town) (County) (State) <u>COLUMAR MARINE PARK, MD</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC. - SILVER SPRING, MD</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

15643

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE VIRGINIA b. COUNTY ARLINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
3. NAME OF DECEASED (Type or print) First Louise Middle A. Last Lewis		4. DATE OF DEATH Month Nov. Day 18 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/1880
9. AGE (in years last birthday) 87 yrs		F UNCO 1 YEAR Months Oays IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK Aldridge		14. MOTHER'S MAIDEN NAME Didie, Franklin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 230-40-3967	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cerebral vascular disease DUE TO disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) generalized arteriosclerosis DUE TO 20 yrs (c) 20 yrs		INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 12 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4/21		20f. (City or town) (County) (State) 11/18	
21. I certify that (I) (this hospital) attended the deceased from 4/21 , 19 66 , to 11/18 , 19 67 , that (I) (we) last saw the deceased alive on 11/18 , 19 67 , and that death occurred at 3:30 AM , from causes and on the date stated above			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 11/18/67	
22c. PHYSICIAN'S NAME (Type) H. E. Kreuzburg		22d. ADDRESS 7852 16th St NW Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City or town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Ives Funeral Home		25a. REC'D BY REGISTRAR 2347 Wilson Blvd. Arlington, Virginia	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. DATE NOV 22 1967	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15650

15645

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b DOA	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSP.		d. STREET ADDRESS 8208 NEW HAMPSHIRE AV	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) MARY LILLIAN LISK		4 DATE OF DEATH 11-27 19 67	
5 SEX Fe	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-25-95 72 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) NORTH CAROLINA		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME GEORGE WILHELM		14 MOTHER'S MAIDEN NAME JULIE RITCHIE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO.	
17 INFORMANT MISS JULIE LISK Address SAME - DTR.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D. EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		22. DATE SIGNED Nov. 27, 1967	
23a BURIAL, CREMATION, REMOVAL (Specify) Removal	23b DATE THEREOF Nov 28, 1967	23c NAME OF CEMETERY OR CHURCH Lefler Funeral Home	23d LOCATION (City or town) (County) (State) Albemarle North Carolina
24 FUNERAL DIRECTOR F. Gasch'S Sons Address Hyattsville, Md.		25a REC'D BY REGISTRAR DEC 1 1967	25b REGISTRAR'S SIGNATURE Charles Judge

15651

CERTIFICATE OF DEATH

15646

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>43 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>		d. STREET ADDRESS <u>Ijamsville, Maryland</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Rosella Long</u>		4. DATE OF DEATH Month Day Year <u>November 11 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10 September 1916</u> 51 yrs.
9. AGE (In years last birthday) <u>51</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Milton Younkin</u>	
14. MOTHER'S MAIDEN NAME <u>Emma McKenzie</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>212-34-9608</u>		17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Scleroderma Kidney</u> DUE TO (c) <u>Progressive Systemic Sclerosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> <u>8 Weeks</u> <u>12 Months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>29 Sept.</u> , 19 <u>67</u> , to <u>11 Nov.</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11 Nov.</u> , 19 <u>67</u> , and that death occurred at <u>2:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Harry R. Keiser MD.</u> M.D.		22b. DATE SIGNED <u>11 November 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harry R. Keiser, MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>Grantsville</u>	23d. LOCATION (City or Town) (County) (State) <u>Grantsville, Maryland</u>
24. FUNERAL DIRECTOR <u>Francis J. Collins</u>		25a. REC'D BY REGISTRAR <u>NOV 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>3821-14th St NW Wash DC</u>	

15652

CERTIFICATE OF DEATH

15647

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>District of Columbia</u> COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>4 hours</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>1600 Pennsylvania Avenue, N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ferdinand</u> Middle <u>(none)</u> Last <u>Louvat</u>		4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 8, 1914</u>
9. AGE (In years last birthday) <u>53 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Pastry Chef</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government (The White House)</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ferdinand Louvat</u>		14. MOTHER'S MAIDEN NAME <u>Felicie Tocat</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>155-34-0244</u>	
17. INFORMANT <u>The Medical Record</u>		18. ADDRESS <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute</u> DUE TO (b) <u>Rhabdomyosarcoma, Metastatic to Lungs</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>20 November 1967</u> , to <u>20 Nov., 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>20 November 1967</u> , and that death occurred at <u>9:50 M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Jean B. de Kernion</u>		22b. DATE SIGNED <u>11/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jean B. de Kernion, M. D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VOIRON</u>	23d. LOCATION (City or Town) (County) (State) <u>VOIRON, FRANCE</u>
24. FUNERAL DIRECTOR <u>H. Don, DeVos</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John A. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15653

CERTIFICATE OF DEATH

15648

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY Dist. of Col. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADA Middle ELIZABETH Last LUEDTKE		4. DATE OF DEATH Month Nov. Day 6 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-1877
9. AGE (In years last birthday) 90 yrs		10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Alabama
10b. KIND OF BUSINESS OR INDUSTRY - - -		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jonas Aderholdt		14. MOTHER'S MAIDEN NAME Frances Carpenter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Cecilia L. Moore, 5147 Mass. Ave. N.W.		Address Wash. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA LEFT BREAST DUE TO WITH GENERALIZED METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 MONTHS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY 10 , 19 67 , to NOV 6 , 19 67 , that (I) (we) last saw the deceased alive on NOV 6 , 19 67 , and that death occurred at 6 M, from causes and on the date stated above			
22a. SIGNATURE Charles J. Francisco, M.D.		22b. DATE SIGNED Nov 6, 1967	22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-9-1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. REC'D BY REGISTRAR NOV 9 1967	25b. REGISTRAR'S SIGNATURE Johnas Judge
ADDRESS 5130 Wisc. Ave. N.W. Wash. D.C.			



CERTIFICATE OF DEATH

15654

15649

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>15</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>4003 Byrd Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Ma</u> Last <u>Ma</u>		4. DATE OF DEATH Month <u>November</u> , Day <u>19</u> , Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-93</u>
9. AGE (In years last birthday) <u>74</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Fellers</u>		14. MOTHER'S MAIDEN NAME <u>Antonia Melintz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-32-534</u>	
17. INFORMANT <u>Amy R. Fellers</u>		Address <u>4003 Byrd Road, Kensington, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of sigmoid colon</u> DUE TO (b) <u>Carcinoma of sigmoid colon</u> DUE TO (c) <u>about 1 year</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 months</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>October 19, 1967</u> , to <u>Nov. 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/8/67</u> , 19 <u>67</u> , and that death occurred at <u>7:25 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Michael S. Madeloff</u>		22b. DATE SIGNED <u>11/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MICHAEL S. MADELOFF M.D.</u>		22d. ADDRESS <u>10620 Georgia Ave. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENHILL CEMETERY</u>	23d. LOCATION (City or town) _____ (County) _____ (State) <u>MARTINSBURG W. Va.</u>
24. FUNERAL DIRECTOR <u>Donald Eckles-Hopfenberg, W. Va.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 22 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	



15655

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b STATE <u>Maryland</u> c COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bechtelsville</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>4826 Butterfield Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>A</u> Last <u>MacLeod</u>		4 DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/3 1896</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>		9b KIND OF BUSINESS OR INDUSTRY <u>—</u>	9c AGE (In years last birthday) yrs <u>71</u>
10a USUAL RESIDENCE (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>		11 BIRTHPLACE (County & State or foreign country) <u>WASHINGTON, D.C.</u>	
13 FATHER'S NAME <u>—</u>		14 MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>—</u>	
17 INFORMANT <u>Helen L. MacLeod - See Item #2.</u>		Address <u>—</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Insufficiency</u> DUE TO (b) <u>Thrombosis Left Subclavian Artery</u> DUE TO (c) <u>Generalized Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>undetermined</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 15</u> , 19 <u>65</u> , to <u>Nov. 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 12</u> , 19 <u>67</u> , and that death occurred at <u>11 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Stanley M. Bialek</u>		22b DATE SIGNED <u>12 Nov 67</u>	
22c PHYSICIAN'S NAME (Type) <u>Dr. Stanley M. Bialek</u>		22d ADDRESS <u>8218 Wise Ave. Beth. Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>11-16-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24 FUNERAL DIRECTOR <u>Joseph Lawler's Sons, Inc. 5130 Wise Ave. NW. Wash. D.C.</u>		25a REC'D BY REG. STRAR DATE <u>NOV 20 1967</u>	25b REGISTRAR'S SIGNATURE <u>William J. Jones</u>



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15651

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c LENGTH OF STAY IN It <u>10 years</u> d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>8805 Plymouth St., Apt. 5</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d STREET ADDRESS <u>8805 Plymouth St. # 5</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>John Grant Mac Minn</u> First Middle Last 4 DATE OF DEATH <u>11 29 1967</u> Month Day Year		5 SEX <u>M</u> COLOR OR RACE <u>W</u> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <u>08 10-24-07x</u> 9 AGE (In years last birthday) <u>59</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>MAINTENANCE</u> 11 BIRTHPLACE (State or foreign country) <u>N. Carolina</u> 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u> 14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u> <u>WW II</u> 16 SOCIAL SECURITY NO. <u>yes</u> 17 INFORMANT <u>Florence Mac Minn</u> <u>8805 Plymouth Street Silver Spring, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>myocardial infarction; Coronary</u> (c) <u>artery heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		22. DATE SIGNED <u>Nov. 29, 1967</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b DATE THEREOF <u>Dec. 4, 1967</u> 23c NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u> 23d LOCATION (City or Town) (County) (State) <u>Rochester, Massachusetts</u>	
24 FUNERAL DIRECTOR <u>John B. Thomas & Son, Inc.</u> <u>8434 Georgia Avenue</u> <u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u>		25a REC'D BY REGISTRAR <u>DEC 5 1967</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

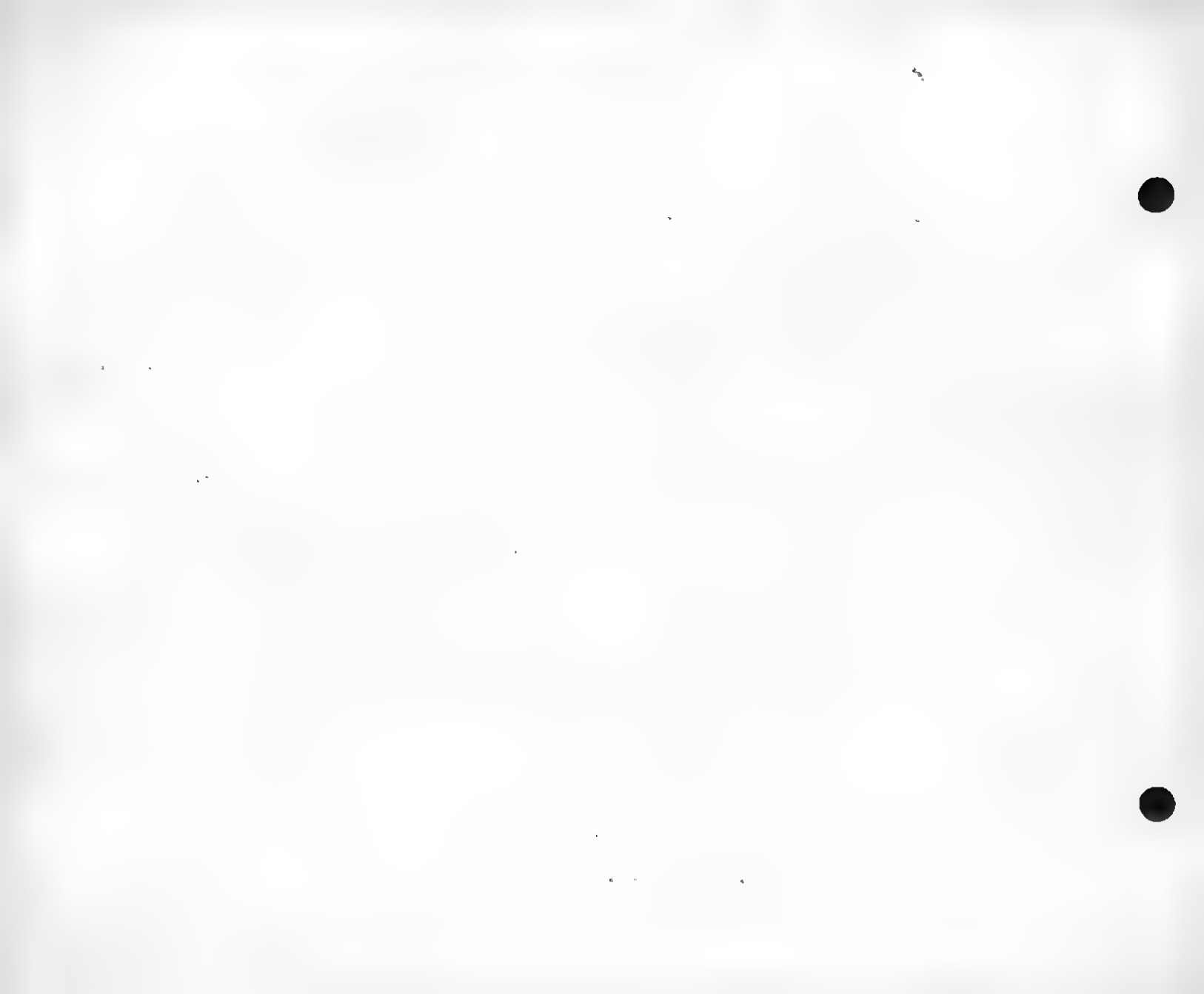
15652

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VM3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c LENGTH OF STAY IN 1b <u>15</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>MONTGOMERY GEN HOSPITAL</u>		e STREET ADDRESS <u>3504 Chiswick Court, World</u>	
3. NAME OF DECEASED (Type or print) <u>Gerald Harper Mains</u>		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/24/93</u>
9. AGE (In years last birthday) <u>74 7/2 yrs</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>chemical engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>plastics</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer Mains</u>		14. MOTHER'S MAIDEN NAME <u>Alice Easton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOC. SEC. NO. <u>162-05</u>	
17. INFORMANT <u>Montgomery General Hospital records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMAL DISEASE CONDITION GIVEN IN PART I (a): <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>Dec. 1, 1967</u>	
EXAMINER'S NAME (Type) <u>Belden R. Reap, M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Robert</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>1 Dec 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Airy Baptist Church</u>	23d. LOCATION (City or town) (County) (State) <u>Wheaton, MD</u>
24. FUNERAL DIRECTOR <u>Charles Sons On</u>		25a. REC'D BY REGISTRAR <u>DEC 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			



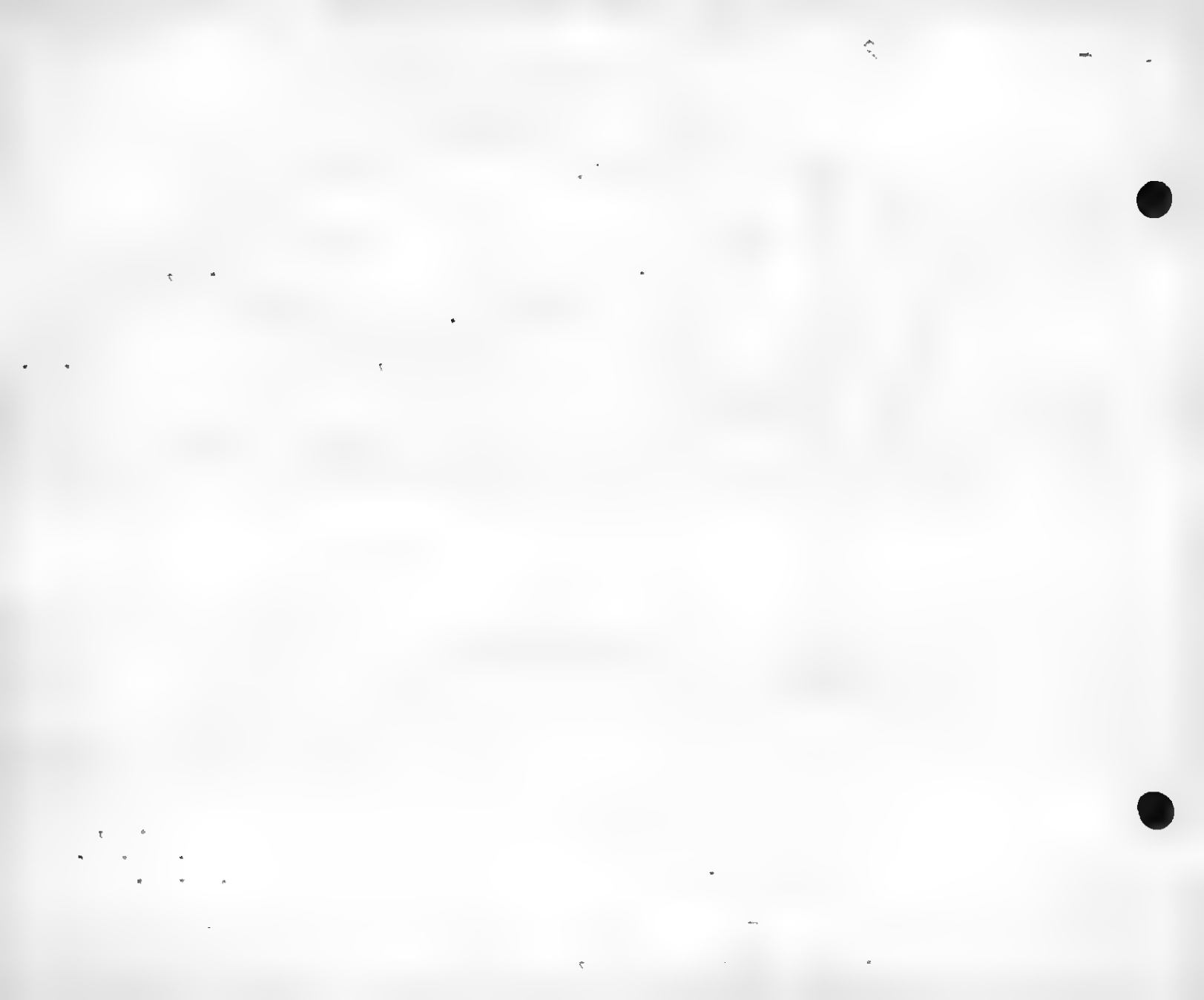
15658

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Ohio b. COUNTY Hamilton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cincinnati	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9216 Cedar Way		d. STREET ADDRESS 1538 Clovernoll Drive	
3 NAME OF DECEASED (Type or print) KARL H. MALLUVIUS		4. DATE OF DEATH Month Nov. Day 5 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Mar. 27, 1905
9 AGE (in years last birthday) yrs 62		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter	
10b KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (County & State, or foreign country) Bremen, Germany	
12 CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Otto Malluvius	
14 MOTHER'S MAIDEN NAME Helena Krezemeier		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Daughter Ursula Davidson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE DUE TO (b) METASTATIC CANCER DUE TO (c) CANCER OF COLON		INTERVAL BETWEEN ONSET AND DEATH 8 MOS. 8 MOS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from AUG , 19 67 , to 11/5 , 19 67 , that (I) (we) lost saw the deceased alive on 11/3 , 19 67 , and that death occurred at 6:02 AM , from causes and on the date stated above.			
22a. SIGNATURE Herbert A. Moskovitz		22b. DATE SIGNED Nov. 5, 1967	
22c. PHYSICIAN'S NAME (Type) HERBERT A. MOSKOVITZ		22d. ADDRESS 916 - 19th St., N. W. Washington, D. C.	
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 11-7-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or town) (County) (State) Suitland, Maryland
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE NOV 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form, PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

15659

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15654

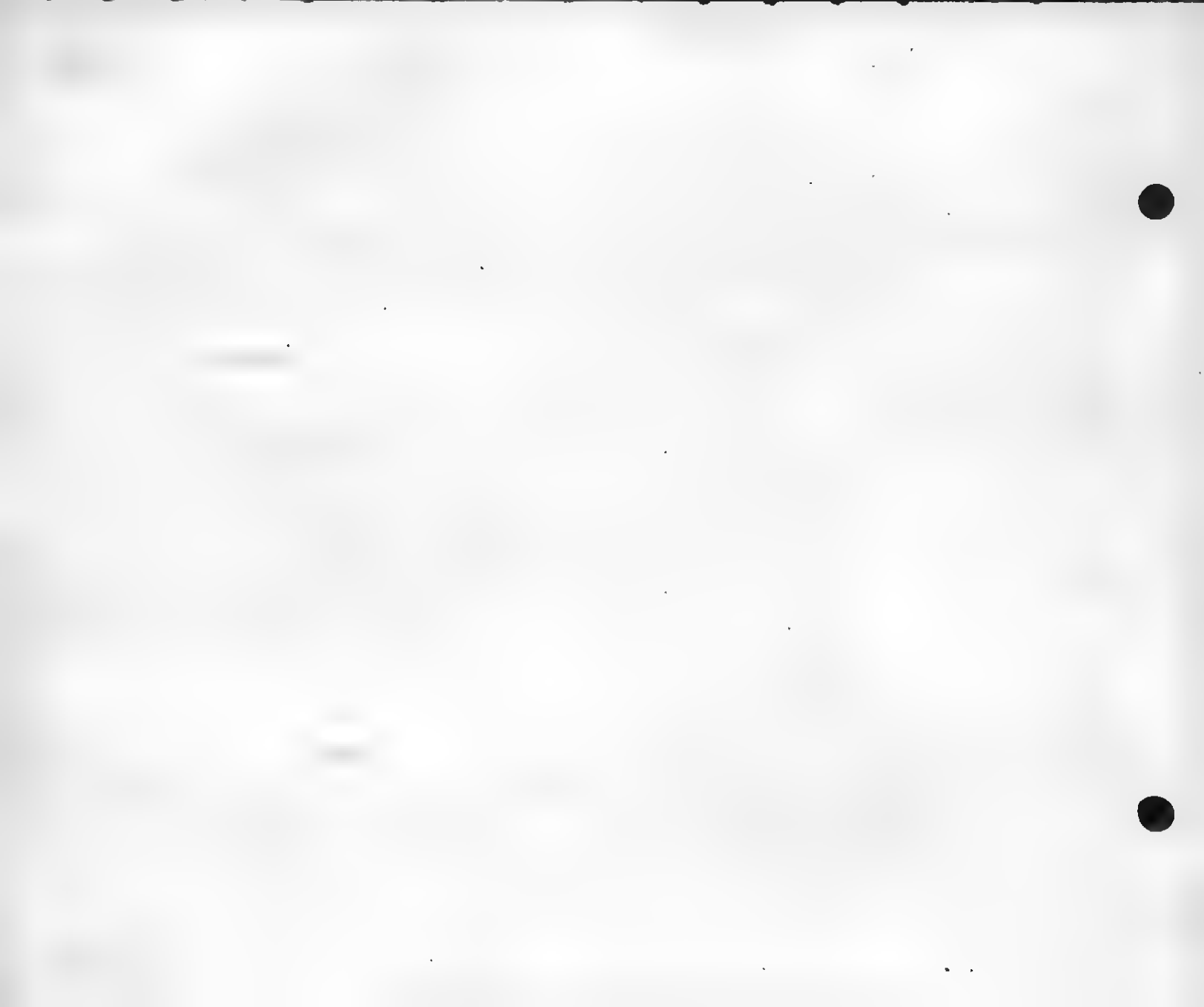
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY <u>Nb</u> <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hosp.</u>		d. STREET ADDRESS <u>5453 Newton St. #7</u>	
3. NAME OF DECEASED (Type or print) <u>George Henry Manning Sr.</u>		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-07</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of workable life even if retired) <u>Sr. sten.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Manning</u>		14. MOTHER'S MAIDEN NAME <u>ALICE Franks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>577105963</u>	
17. INFORMANT <u>MRS N. LOUISE MANNING</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4301</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b) and (c) <u>Diabetes Mellitus</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-14-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>COLMAR MANOR, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. RIVERDALE, MD</u>		25a. REC'D BY REGISTRAR <u>Nov. 14, 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>Nov. 11, 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>						c. LENGTH OF STAY IN MD					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2311 PLYERS MILK RD.</u>						d. STREET ADDRESS <u>2311 PLYERS MILK RD.</u>					
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>I.</u> Last <u>MARCHI</u>						4. DATE OF DEATH Month <u>11</u> Day <u>NOV</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>30 JUNE 1882</u>		9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR (If UNDER 24 HRS. Months Days Hours Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL MANUFACTURING</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>ITALY - WCCS.</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>
13. FATHER'S NAME <u>BASILIO MARCHI</u>						14. MOTHER'S MAIDEN NAME <u>CELESTE BARSOTTI</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>579-69-608A</u>		17. INFORMANT <u>JULIUS C. MARCHI</u> Address <u>1074 Ocean Ave S.S. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis Cardiac disease</u> 10 years											
DUE TO (c) <u>Emphysema</u> 3 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>1967</u> , that (I) (we) last saw the deceased alive on <u>11/14</u> 1967, and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>R. N. Mangano</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/14/67</u>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>15 Nov. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		23d. LOCATION (City, town or county) (State) <u>SILVER SPRING MD.</u>			
24. FUNERAL DIRECTOR <u>RINDA FUNERAL HOME INC.</u> ADDRESS <u>1406 GREGG AVE. NW</u>						25a. REC'D BY REGISTRAR <u>NOV 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15661

CERTIFICATE OF DEATH

15656

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 59 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingston		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland			d. STREET ADDRESS 26 West Bennett Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Harold Middle Lewis Last Mark			4 DATE OF DEATH Month November Day 13 Year 1967		
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 November 1946		9. AGE (in years last birthday) 21 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13 FATHER'S NAME Sidney Mark			12 CITIZEN OF WHAT COUNTRY? USA		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16 SOCIAL SECURITY NO		
17 INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram-negative septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute perforation of appendix DUE TO (c) Acute myelogenous leukemia		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intracranial hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 17 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) 13	(County)	(State)
21. I certify that (A) (this hospital) attended the deceased from September 15, 1967 to November 7, 1967 , that (A) (we) last saw the deceased alive on November 13, 1967 , and that death occurred at 5:20M , from causes and on the date stated above.					
22a. SIGNATURE Thomas Clancy M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 13 Nov. 1967
22c. PHYSICIAN'S NAME (Type) Thomas Clancy, MD			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.		
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b. DATE THEREOF 11/14/1967	23c. NAME OF CEMETERY OR CREMATORY W. Pittston Jewish Cem	23d. LOCATION (City or town) W. Pittston Luzerne Co., Pa	(County)	(State)
24. FUNERAL DIRECTOR Samuel L. Rosenberg		ADDRESS Wells Barre		25a. REC'D BY REGISTRAR NOV 16 1967	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 20&21 Film 395

11-27-67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15662

CERTIFICATE OF DEATH

13^57

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland b COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 2253 Hannon Street, W e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence Ashby Marshall		4. DATE OF DEATH Month November Day 10 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-28-92
9 AGE (In years lost birthday) 75 yrs		10 IF UNDER 1 YEAR Months 10 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, and character) Retired Flooring		10b. KIND OF BUSINESS OR INDUSTRY Building	
11 BIRTHPLACE (County & State, or foreign country) Washington D.C.		12 CIT ZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Clarence W. Marshall		14. MOTHER'S MAIDEN NAME Sally Golden	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16 SOCIAL SECURITY NO. 578-20-8715	
17 INFORMANT Blanche Marshall Address 2253 Hannon Street, W. Hyattsville, Md. Patient's Chart			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Fulminating bilateral pneumonia DUE TO (b) Post surgery hip nailing ; severe extensive DUE TO (c) Arteriosclerosis ; Diabetes Mellitus. 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 8 days 8 days 4-5 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (F EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in nursing home & fractured hip	
20c TIME OF INJURY Month, Day, Year Hour a.m. 9-28 19 67 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) Nursing home	20f (City or town) (County) (State) Hyattsville Pr. Geo. Md.
21. I certify that (I) (this hospital) attended the deceased from May, 1961 , to Nov 10, 1967 , that (I) (we) last saw the deceased alive on Nov 9 1967 , and that death occurred at 5:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert B. Irey		22b. DATE SIGNED 11-10-67	
22c. PHYSICIAN'S NAME (Type) ROBERT B. IREY		22d. ADDRESS 11161 New Hampshire Ave, Silver Spring	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Nov. 13, 1967	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION (City or Town) (County) (State) Switland, Maryland
24 FUNERAL DIRECTOR'S NAME (Type) C. Glen Carter		25a REC'D BY REGISTRAR Warner E. Pumphrey, Inc.	25b REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>		d. STREET ADDRESS <u>5011 North 4th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>L.</u> Last <u>MARTIN</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1908</u>
9. AGE (In years last birthday) <u>59</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dayd City, Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse Earl Martin</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Blair</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>230-48-9263</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary emboli, massive bilateral</u> DUE TO (b) <u>Carcinoma of the stomach</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>Aug. 25</u> , 19 <u>67</u> , to <u>Nov. 29</u> , 19 <u>67</u> , that (t) (we) last saw the deceased alive on <u>Nov. 29</u> , 19 <u>67</u> , and that death occurred at <u>8:15 P. M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>James E. Davis</u>		22b. DATE SIGNED <u>30 Nov 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James E. Davis</u>		22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE THEREOF <u>12-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Arlington Funeral Home</u> <u>3901 North Fairfax Drive, Arlington, Va.</u>		25a. REC'D BY REGISTRAR <u>DEC 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

15664

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>	
c. LENGTH OF STAY IN 1b <u>28 days</u>		d. STREET ADDRESS <u>2717-S. Walter Lindley</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Urban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Storothy Julia Martin</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/2/19</u> 48 yrs
9a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Private</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	
10a. U.S. AL BIRTHPLACE (County & State, or foreign country) <u>Conn.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>George Adams</u>		14. MOTHER'S MAIDEN NAME <u>Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>222</u>	
17. INFORMANT <u>Lewis Owen Martin</u>		Address <u>2717-S. Walter Lindley</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>163X</u> IMMEDIATE CAUSE (a) <u>Pulmonary Carcinoma</u> DUE TO (b) <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>163X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 1B)	
20c TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Apartment</u>		20f (City or town) <u>Nov</u> (County) <u>1967</u> (State) <u>1967</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> to <u>Nov</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/5/67</u> 19 <u>67</u> , and that death occurred at <u>3:30</u> P.M. from causes and on the date stated above.			
22a SIGNATURE <u>Jay R. Shapiro</u>		22b DATE SIGNED <u>11-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAY R. SHAPIRO</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Avenue, Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>11-18-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Fairfield Mem. Park</u>		23d LOCATION (City or Town) <u>Stamford, Conn.</u> (County) (State)	
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>NOV 17 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

<div>15665</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>15660</div>												
<div>Kensington Gardens San.</div> <div>CERTIFICATE OF DEATH</div>												
1 PLACE OF DEATH a COUNTY <u>Kensington</u> <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>						
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington Md.</u>				c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens San.</u>						d STREET ADDRESS <u>25 East Wayne Avenue</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) <u>Sophia S. Maskell</u>						4. DATE OF DEATH Month <u>Nov</u> Day <u>8</u> Year <u>1967</u>						
5 SEX <u>F</u>		6 COLOR OR RACE <u>W.</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>5-2-81</u>		9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Halifax, Nova Scotia</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>William Sutherland</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Matheson</u>						
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16 SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Charles Maskell</u> <u>25 East Wayne Avenue Silver Spring, Md.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>1-2 mo</u> <u>1</u>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Thrombosis</u>										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>8 mo</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6 mo</u> 19 <u>67</u> and that death occurred <u>4:20 pm</u> from causes and on the date stated above.												
22a SIGNATURE <u>William D. And</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <u>11/8/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>William D. And</u>						22d. ADDRESS <u>9006 Colesville, Rd. Silver Spring, Md.</u>						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
<u>Trans-burial</u>			<u>Nov. 11, 1967</u>		<u>Milton Cemetery</u>				<u>Boston, Massachusetts</u>			
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u> <u>8434 Georgia Avenue</u> <u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u> <u>Clark E. Wisor</u>						25a REC'D BY REGISTRAR <u>NOV 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

CERTIFICATE OF DEATH

15661

15665

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). a. STATE <u>Virginia</u> b. COUNTY <u>Nelson</u> ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN It <u>226 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Roseland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014</u> <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>Route 1, Box 13B</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Inetta</u> Middle <u>(None)</u> Last <u>Mason</u>				4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 December 1933</u>	9. AGE (In years last birthday) <u>33</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Mason</u>				14. MOTHER'S MAIDEN NAME <u>Anna Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unavailable</u>		17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland 20014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mycosis Fungoides</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>March 21</u> , 19 <u>67</u> , to <u>November 2</u> , 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>Nov. 2</u> , 19 <u>67</u> , and that death occurred on <u>12:35 M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Arthur N. Kales</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> AM <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2 November 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur N. Kales, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-4-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY</u>		23d. LOCATION (City or town) (County) (State) <u>LANDOVER, Md</u>	
24. FUNERAL DIRECTOR <u>FRAZIER'S - WASHINGTON, D.C.</u>				25a. REC'D BY REGISTRAR <u>NOV 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

CERTIFICATE OF DEATH

15662

15662

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery - MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1513 Woodman Avenue		d. STREET ADDRESS 1513 Woodman Avenue	
3. NAME OF DECEASED (Type or print) JOHN BRADBURN MATHews		4 DATE OF DEATH Month Nov. Day 10 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-24-1923
9 AGE (in years) 44 yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Department of Defense		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11 BIRTHPLACE (County & State, or foreign country) South Dakota		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Oscar Mathews		14. MOTHER'S MAIDEN NAME Adelaide Bradburn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 2-1943 to 10-1943		16. SOCIAL SECURITY NO. 3-579-26-1847	
17. INFORMANT Georgia Ann Mathews-See Item No. 2		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Lung 165X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Approx 7
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April, 1967, to Nov 10, 1967, that (I) (we) last saw the deceased alive on Nov 9, 1967, and that death occurred at 5 A.M. from causes and on the date stated above			
22a. SIGNATURE BLAINE HZEIG		22b. DATE SIGNED Nov 10, 1967	
22c. PHYSICIAN'S NAME (Type) BLAINE HZEIG		22d. ADDRESS 2641 Coleridge Rd Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 11-14-1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l. Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR DATE NOV 15 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

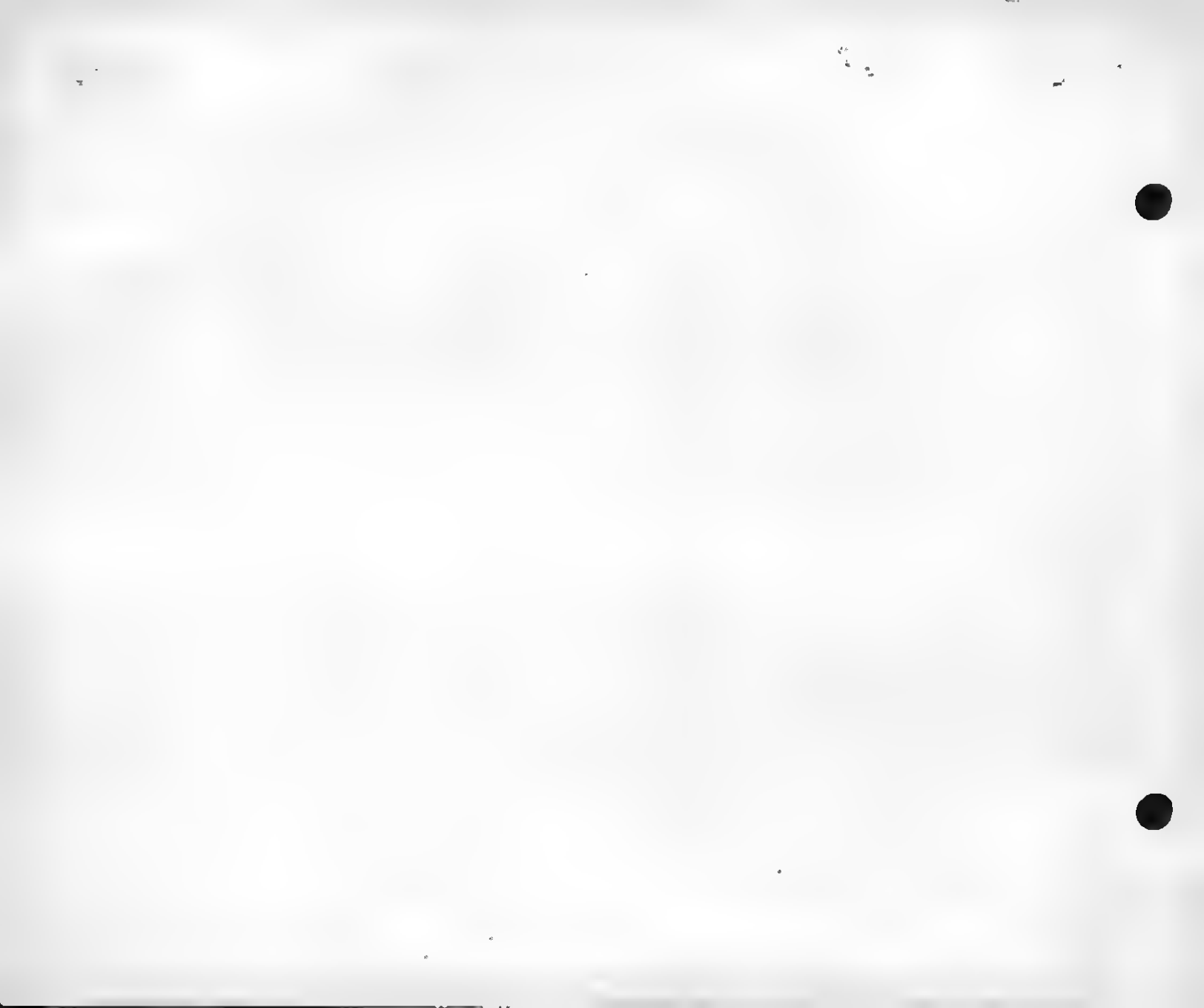
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15668

15663

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN Ia <u>3 1/2 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>211 Cedar Avenue</u>		d. STREET ADDRESS <u>211 Cedar Avenue</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Will</u> <u>G.</u> <u>Montee</u>		4 DATE OF DEATH Month Day Year <u>Nov</u> <u>15</u> <u>1967</u>	
5 SEX <u>Female</u>	6 CO. OR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 26, 1895</u>
9 AGE (In years of birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months Days Hours Min <u>15</u> <u>19</u> <u>67</u>	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>William Montee</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Pardum</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213 50 5016</u>	
17 INFORMANT <u>Mr. Evelyn Selby - Sister</u>		Address <u>Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>2865</u> IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> DUE TO (b) <u>Malnutrition</u> (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>One Month</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-13</u> , 19 <u>67</u> , to <u>11-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-14</u> , 19 <u>67</u> , and that death occurred at <u>12:20</u> M, from causes and on the date stated above			
22a SIGNATURE <u>William L. Lisle</u>		22b DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) <u>L. I. Lisle</u>		22d ADDRESS <u>Medic 1 Center, Rockville, Md.</u>	
23a BURIAL, CREMAT. OR REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>11/18/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Darnestown</u>	23d LOCATION (City or town) (County) (State) <u>Darnestown, Maryland</u>
24 FUNERAL DIRECTOR <u>Tyner Wheeler Funeral Home</u>		25a REC'D BY REGISTRAR DATE <u>NOV 17 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15668

CERTIFICATE OF DEATH

15664

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>DoA</u>		d. STREET ADDRESS <u>7017 Wagstaffe</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>David O. McDonough</u>		4. DATE OF DEATH <u>Nov 14 1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/31/67</u>
9 AGE (in years last birthday) <u>2 mos</u> YRS		F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Mont</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Joseph McDonough</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Oliver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Patrick J. McDonough</u>		Address <u>7017 Wagstaffe</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> <u>1040</u> DUE TO (b) <u>(Common truncus, trilobular)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>3/31/67</u> , 19 <u>67</u> , to <u>11/14/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/13/67</u> , 19 <u>67</u> , and that death occurred at <u>11/14/67</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J. C'Donnell</u>		22b. DATE SIGNED <u>11/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vincent J. C'Donnell</u>		22d. ADDRESS <u>5415 W. Cedar La Bethesda</u>	
23a. BURIAL, CREMATION, REMAINS (Specify)		23b. DATE THEREOF <u>11/16/67</u>	
23c. LOCATION (City or town) (County) (State) <u>Silver Spring, Md.</u>		23d. NAME OF TRANSFER OR CREMATORY <u>GATE OF HEAVEN</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler, Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN TB <i>4 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		2 USUAL RESIDENCE (Where deceased lived, if not in on residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> d. STREET ADDRESS <i>100 Lucas Lane</i> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Honey Thomas Mc Gaughan</i>		4 DATE OF DEATH Month Day Year <i>Nov 24 1967</i>	
5 SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-29-81</i>
9 AGE (In years last birthday) <i>86</i> yrs.		10 UNDER 1 YEAR Months Days Hours Min	11 UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>conservator (civil)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self-employed</i>	
11 BIRTHPLACE (County & State, or foreign country) <i>Bay City, Michigan</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13 FATHER'S NAME <i>Alexander Stanley Mc Gaughan</i>		14 MOTHER'S MAIDEN NAME <i>Ida Little</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no.</i>		16 SOCIAL SECURITY NO <i>366-34-7322</i>	
17 INFORMANT -son <i>P. Stanley Mc Gaughan</i>		Address <i>100 Lucas Lane Bethesda MD</i>	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diagnosis: 201000</i> DUE TO <i>Cancer of Bladder</i> (b) <i>Cancer of Lung</i> (c) <i>Senility</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <i>11/11/67</i> , 19 <i>67</i> to <i>11/24/67</i> , that (I) (we) last saw the deceased alive on <i>11/23/67</i> , and that death occurred at <i>12 PM</i> , from causes and on the date stated above			
22a SIGNATURE <i>W. T. Joyce</i>		22b DATE SIGNED M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) <i>W. T. Joyce</i>		22d ADDRESS <i>4977 Battery Lane Bethesda MD</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b DATE THEREOF <i>11/27/67</i>	23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	23d LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>
24 FUNERAL DIRECTOR <i>Joseph Gawler's Sons</i>		ADDRESS <i>5130 Wisconsin Ave. N.W.</i>	25a REC'D BY REGISTRAR DATE <i>DEC 4 1967</i>
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15666

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms BM-3, Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>MDNTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>D.C.</u>	
b CITY OR TOWN (If outside corporate limits write P.M.S. and give nearest town) <u>Bethesda</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d STREET ADDRESS <u>1730 H. Street N.W.</u>	
3 NAME OF DECEASED (Type or print) <u>ALBERT</u> First <u>1</u> Middle <u>MC</u> Last <u>GEACH</u>		4 DATE OF DEATH <u>Nov</u> Month <u>28</u> Day <u>19</u> Year <u>67</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-1901</u>
9 AGE (In years last birthday) <u>66</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Analyst - common government</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Mc Geach</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED IN U.S. ARMED FORCES? (Yes no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>065-05-1853</u>	
17. INFORMANT <u>George Mc Geach</u> Address <u>266 E 32nd St Brooklyn</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Recent & Remote</u> DUE TO <u>4201</u> (and trans, if any, which gave rise to immediate cause (a) stating the underlying cause last.) (b) <u>Coronary Arteriosclerosis</u> (c) <u>Years.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		22. DATE SIGNED <u>11/28/67</u>	
EXAMINER'S NAME (Type) <u>John B. Ball</u>		22. DATE SIGNED <u>11/28/67</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/1/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>BROOKLYN, NEW YORK</u>	
24. FUNERAL DIRECTOR <u>ROBERT E. WILHELM FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>DEC 1 1967</u>	
4308 SUTLAND ROAD, SUTLAND, MARYLAND		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

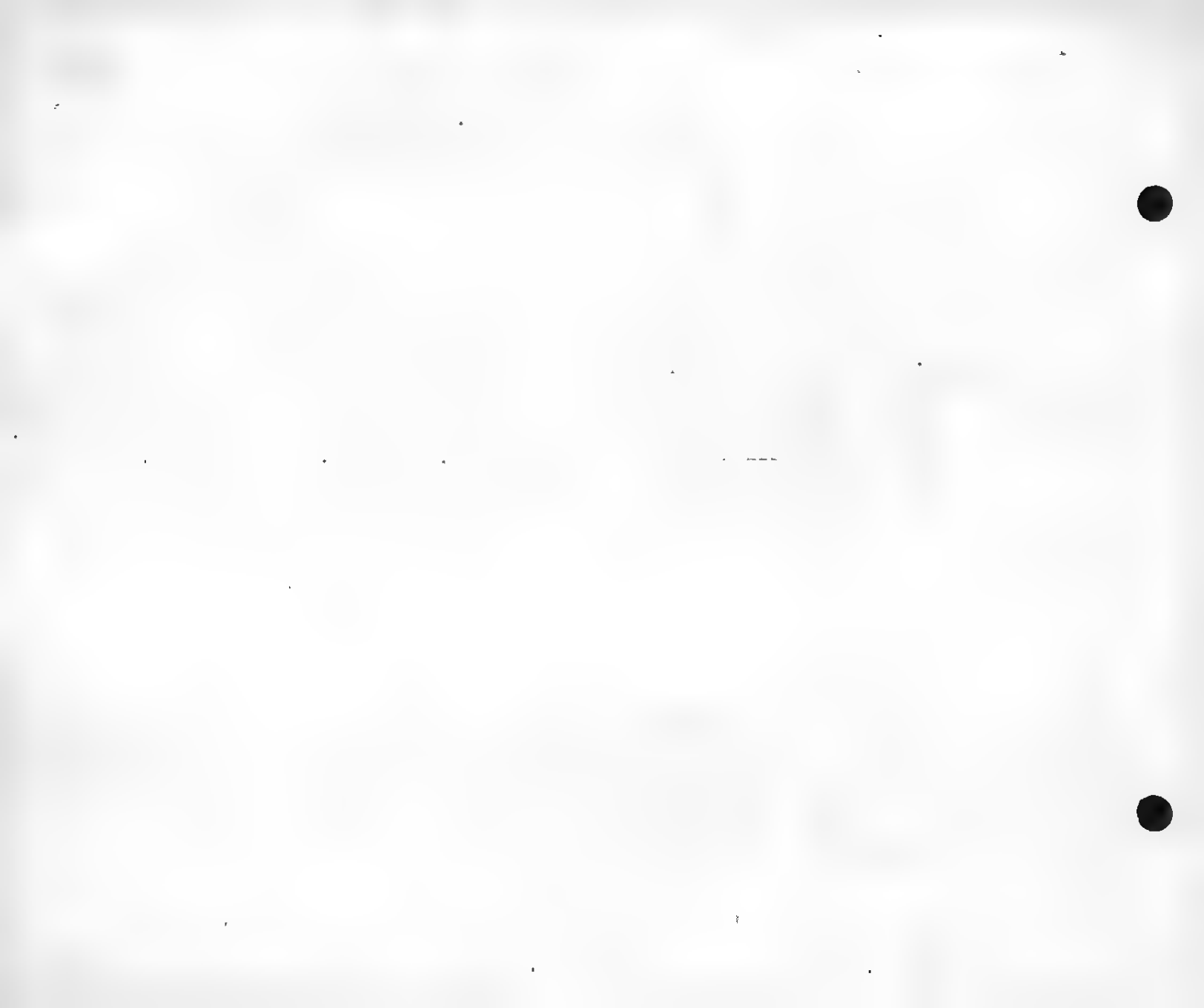
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15672

15667

1 PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>5826 Vandergrift Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Mrs Cora Rebecca McGill</u>		4 DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29, 1893</u> 74 yrs
9 AGE (In years lost birthday) <u>74</u> yrs		10. USUAL OCCUPATION (Give kind of work done during part of which deceased died) <u>Ret. Homemaker</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Henry King</u>	
14. MOTHER'S MAIDEN NAME <u>Marg Martha Minnick</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>220-26-5526A</u>		17. INFORMANT <u>Mrs. Donald L. Loy Rockville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> to <u>present</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>21 Nov 1967</u> , and that death occurred at <u>10:52 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Paul D. Jones</u>		22b. DATE SIGNED <u>21 Nov 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>?</u>		22d. ADDRESS <u>?</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-25-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Frederick, Maryland</u>
24. FUNERAL DIRECTOR <u>Robert E. Dailey & Son</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
ADDRESS <u>Frederick, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

15673

15668

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c LENGTH OF STAY IN 1b 7 Months	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Nursing Home		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) RUTH MCGOWAN		4. DATE OF DEATH Month Nov Day 10 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 13, 1876
9 AGE (In years last birthday) yrs 91		IF UNDER 24 HRS Months 10 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10b KIND OF BUSINESS OR INDUSTRY Retired	
11 BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 578-62-3277J1	
17. INFORMANT Edward Mitchell		Address Washington, D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Bronchitis DUE TO 450 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO 10 years (c) with senility			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 2, 1950 , to Nov 10, 1967 that (I) (we) last saw the deceased alive on Nov 1, 1967 , and that death occurred at 10:30 A.M. , from causes and on the date stated above			
22a. SIGNATURE Thomas S. Sappington M.D.		22b. DATE SIGNED 11/10/67	
22c. PHYSICIAN'S NAME (Type) Thomas S. Sappington, M. D.		22d ADDRESS 2233 Wisconsin ave., N.W., D. C. 20007	
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b DATE THEREOF 10-11-67	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d LOCATION (City or Town) (County) (State) Suitland, Maryland
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a REC'D BY REGISTRAR NOV 14 1967	25b REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 396
12-20-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15589

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 12-1		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSP.		d. STREET ADDRESS 1100 GADSDEN AVE.	
3 NAME OF DECEASED (Type or print) First Middle Last WILLIAM HAROLD MCKAY		4 DATE OF DEATH Month Day Year NOVEMBER 17 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8 DATE OF BIRTH JUNE 18, 1922 9 AGE (In years last birthday) yrs 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ADMINISTRATIVE CLERK JOHN H. HIKINS		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11 BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME ANDREW MCKAY		14. MOTHER'S MAIDEN NAME EDITH BARNES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW2 Army		16. SOCIAL SECURITY NO. 216-16-5136	
17. INFORMANT MRS. BEVERLY M. MCKAY		Address (Same as #2)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Acute coronary insufficiency DUE TO (b) Coronary artery heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential hypertension			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		22. DATE SIGNED Nov. 18, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. Ignace Cemetery		23d. LOCATION (City or Town) (County) (State) Washington	
24. FUNERAL DIRECTOR Arthur H. H. H.		25a. REC'D BY REGISTRAR Nov 21 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Washington, D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium		d. STREET ADDRESS 4899 Potomac Ave., N.W.	
3 NAME OF DECEASED (Type or print) ARCHIBALD V. MCKEE		4. DATE OF DEATH Month Nov. Day 20 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1897
9 AGE (in years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12. C TIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archibald V. McKee		14. MOTHER'S MAIDEN NAME Anna Marie Hale	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 579-16-5256	
17. INFORMANT Mrs. Helen Y. McKee (wife)		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Coronary Occlusion DUE TO Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left side hemiplegia		INTERVAL BETWEEN ONSET AND DEATH 1 hour Sev. yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 Min PM	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1967 to Nov. 20, 1967 that (I) (was) last saw the deceased alive on Nov. 16, 1967 , and that death occurred at 7:20 PM , from causes and on the date stated above.			
22a. SIGNATURE James H. Heiger, M.D., F.A.C.A.		22b. DATE SIGNED Nov. 20, 1967	
22c. PHYSICIAN'S NAME (Type) James H. Heiger, M.D., F.A.C.A.		22d. ADDRESS 1118 M.D., F.A.C.A.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-24-1967	23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery	23d. LOCATION (City or Town) (County) (State) Oneonta New York
24. FUNERAL DIRECTOR Ives Funeral Home, Inc., 2847 Wilson Blvd.		25a. REC'D BY REGISTRAR Nov 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15678

CERTIFICATE OF DEATH

15671

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN TB <u>10 years</u>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, DC</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Manor Nursing Home</u>		d. STREET ADDRESS <u>1311 Juniper St., N.W., Washington, D.C.</u>	
3 NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>M. McLAUGHLIN</u> Last <u>N</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH <u>June 9, 1878</u>
9 AGE (in years last birthday) <u>89</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Windsor, Ohio</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>William Stanley</u>	
14 MOTHER'S MAIDEN NAME <u>Nancy J. Berous</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>577-07-2877</u>		17. INFORMANT <u>Divian Mac Murray</u> <u>1311 Juniper St., N.W. Washington, D.C.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1201</u> DUE TO (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 3, 1957</u> , to <u>Nov. 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 25, 1967</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Henry London</u>		22b. DATE SIGNED <u>11/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry London</u>		22d. ADDRESS <u>3206 Narrows Dr. Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 30, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Suitland, Maryland</u>	
23e. REGISTRATION <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		23f. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>	
23g. REC'D BY REGISTRAR DATE <u>DEC 1 1967</u>		23h. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>	

15677

CERTIFICATE OF DEATH

15672

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 3 weeks		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 6709 East Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) John Owen McMurrough First Middle Last		4 DATE OF DEATH November 12 1967 Month Day Year	
5 SEX Male	6 COLOR OR RACE Caus.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/13/1886 9 AGE (in years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-coal miner		10b. KIND OF BUSINESS OR INDUSTRY COAL MINE	11 BIRTHPLACE (County & State or foreign country) Balto., Md. 12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME Owen McMurrough		14. MOTHER'S MAIDEN NAME Mary Ellen Sullivan	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no NONE		16 SOCIAL SECURITY NO 178-07-1781	
17 INFORMANT Nursing Home Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 201X IMMEDIATE CAUSE (a) HODGKINS DISEASE DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 10/21, 1967 to 11/12, 1967 that (I) (we) last saw the deceased alive on 11/12, 1967 and that death occurred at 12:00 AM from causes and on the date stated above.			
22a. SIGNATURE Walter E. Goetz M.D.		22b. DATE SIGNED 11/12/67	
22c. PHYSICIAN'S NAME (Type) WALTER E. GOETZ MD		22d. ADDRESS 2309 Shorefield Rd., Wheaton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 15/1967	23c. NAME OF CEMETERY OR CREMATORY ST. VINCENT DE PAUL	23d. LOCATION (City or town) (County) (State) PUNBAR TOWNSHIP - PATER, PA.
24 FUNERAL DIRECTOR W.W. CHAMBERS Co. WASHINGTON, DC.		25a. REC'D BY REGISTRAR NOV 14 1967 DATE	25b. REGISTRAR'S SIGNATURE [Signature]

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

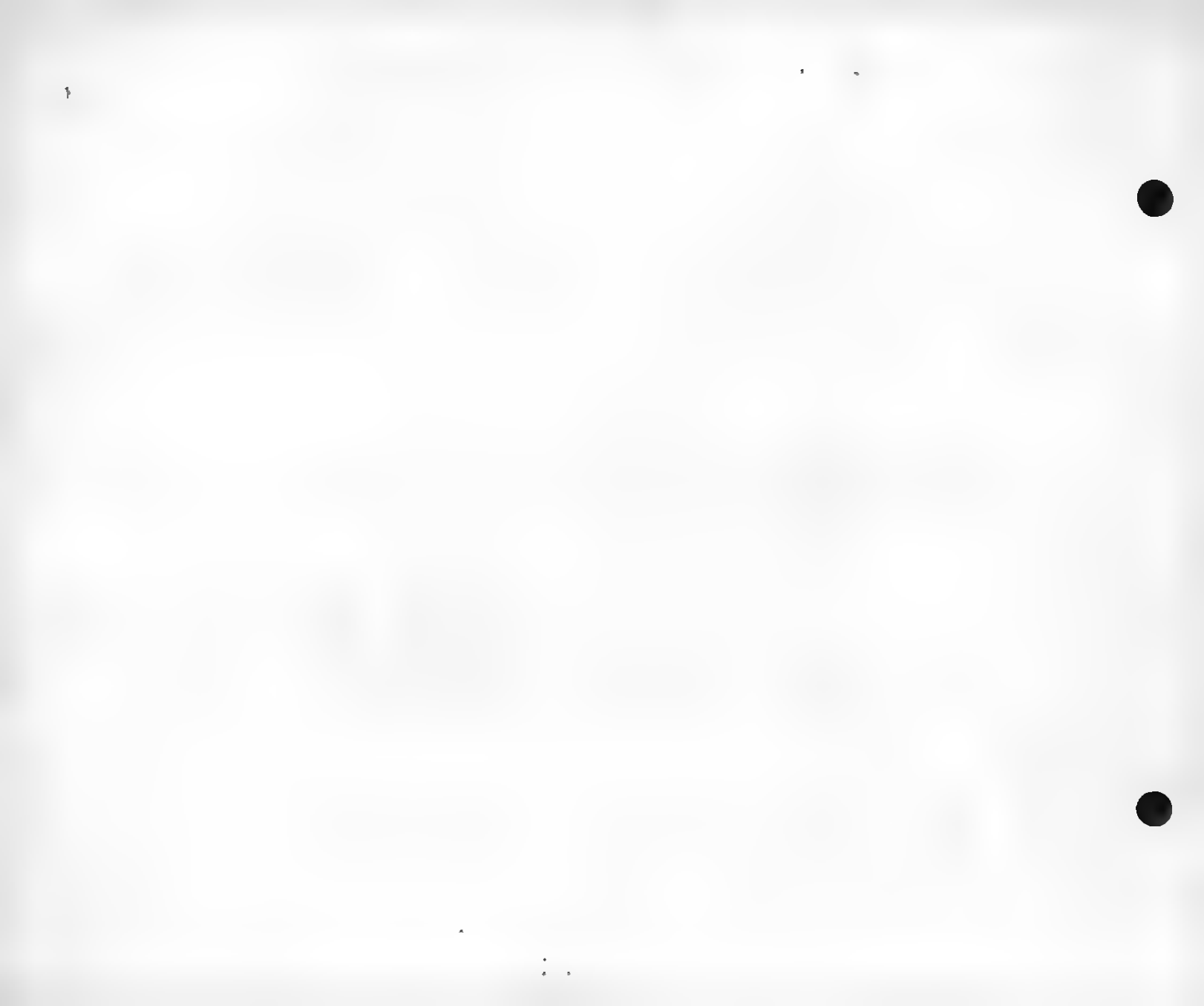
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>SC</u> b COUNTY <u>✓</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>3 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>3601 Wisconsin Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Augustus F. McNaair</u>		4 DATE OF DEATH <u>Nov 14 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-18-1886</u>
9 AGE (In years last birthday) <u>80</u> yrs.		10 IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>19</u> Min <u>67</u>	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>Wisconsin - New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>ELLEN C. McNAIR</u>		14 MOTHER'S MAIDEN NAME <u>Laura McNaair</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Navy</u>		16 SOCIAL SECURITY NO <u>578-52-6471A</u>	
17 INFORMANT <u>Wife - Maurice McNaair</u>		Address <u>Same as above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lymphocytic Leukemia</u> 2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		22. DATE SIGNED <u>11/14/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11-17-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a RECD BY REGISTRAR <u>Nov 20 1967</u>	
25b ADDRESS <u>5130 W. Ash. D.C.</u>		25c REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15673
15674
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>55 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>720 University Blvd. East</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>720 University Blvd. East</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Romaine Tindall Meeds</u> First Middle Last 4. DATE OF DEATH <u>Nov. 26 1967</u> Month Year Day				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 17 1877</u> 9. AGE (In years last birthday) <u>89 yrs.</u> IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Independence, Missouri</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>				13. FATHER'S NAME <u>Robert B. Tindall</u> 14. MOTHER'S MAIDEN NAME <u>Henrietta Eccles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>220-14-1527</u> 17. INFORMANT <u>Romaine Warren</u> Address <u>211 Williamsburg Drive Silver Spring, Maryland</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis, Cardiac Failure</u> DUE TO (b) <u>Cerebral Thromboses Multiple small</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Hip, right, old (1962)</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1962</u> , to <u>Nov 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 24, 1967</u> , and that death occurred at <u>11:16</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>George L. Ball</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>Nov 26, 1967</u>				22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u> 22d. ADDRESS <u>10620 Georgia Ave Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Nov. 28, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>				24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>184 D. Georgia Avenue Silver Spring, Md.</u> 25a. REC'D BY REGISTRAR <u>NOV 28 1967</u> 25b. REGISTRAR'S SIGNATURE <u>William J. Gage</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>3 mo. & 1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. & Hosp.</u>		e. STREET ADDRESS <u>1605 DALE DRIVE</u>	
3 NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>F</u> Last <u>MEHLING</u>		4 DATE OF DEATH Month <u>NOV.</u> Day <u>4</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-9-17</u> 50 51 yrs
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u>		11 BIRTHPLACE (County & State or foreign country) <u>MD.</u>	
13 FATHER'S NAME <u>JOHN MEHLING</u>		12 MOTHER'S MAIDEN NAME <u>LORETTA Judge</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW II</u>		16 SOCIAL SECURITY NO <u>217-07-1473</u>	
17 INFORMANT <u>Catherine F. Mehling</u>		18 ADDRESS <u>1605 Dale Dr. Silver Spring, Md.</u>	
18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, generalized</u> DUE TO (b) <u>Bronchogenic carcinoma, right lung</u> DUE TO (c) <u>1 year</u> 18 months		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>18 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>8-8</u> , 1967, to <u>11-4</u> , 1967, that (I) (we) last saw the deceased alive on <u>11-4</u> , 1967, and that death occurred at <u>4:50</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Eino Magi</u>		22b. DATE SIGNED <u>11-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		22d. ADDRESS <u>831 Univ. Blvd. E. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Nov. 8 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
25a. REC'D BY REGISTRAR <u>Warner E. Humphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15680 15675



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15381

15376

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 15 <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>13803 LOREL LANE</u>	
3 NAME OF DECEASED (Type or print) First <u>Erin</u> Middle <u>Elizabeth</u> Last <u>Merrick</u>		4 DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>November 14, 1967</u>
10a. USUAL OCC. PAT ON (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs <u>4</u> Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min.
11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>James Joseph Merrick</u>		14 MOTHER'S MAIDEN NAME <u>Sherrell Jean Varley</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO -----	17 INFORMANT <u>Father</u> Address <u>as above</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u> DUE TO <u>ic. neonatal osteodysplasia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 days</u> <u>4 1/3 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, all-ice bldg, etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>NOV. 14</u> , 19 <u>67</u> , to <u>NOV. 19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>NOV. 18</u> , 19 <u>67</u> , and that death occurred at <u>6:10 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Edward J. Froli</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED <u>11/19/67</u>
22c PHYSICIAN'S NAME (Type) <u>Dr. E. J. Froli</u>		22d ADDRESS <u>11 Rockville Pike, Rockville, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>11/21/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. of Heav.</u>	23d LOCATION (City or Town) (County) (State) <u>City of Rockville, Md.</u>
24 FUNERAL DIRECTOR <u>John Heeler</u> <u>1371 Rockville Pike, Rockville, Maryland</u>		25a RECD BY REGISTRAR <u>DATE NOV 21 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1-2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form W-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 77 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15682		15677	
1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>DOA</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>429 E. Wisconsin Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Harry Carter Merry</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept 20 - 1884</u>
9 AGE (In years last birthday) <u>83</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Elizabeth R. Merry</u>		14 MOTHER'S MAIDEN NAME <u>Lizzie Carter</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Mrs. Earl Grouse - Niece, Hogersburg</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis, old and recent</u>			
DUE TO (b) <u>Coronary arteriosclerosis, severe</u>			
DUE TO (c) <u>last</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John E. Zell</u> M.D.		22 DATE SIGNED	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>X</u>	23b DATE THEREOF <u>11-14-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Providence</u>	23d LOCATION (City or Town) (County) (State) <u>Lewinsville Va</u>
24 FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a REC'D BY REGISTRAR <u>Phonla Judge</u>	
Address <u>Gaithersburg</u>		DATE <u>NOV 16 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

<div style="display: flex; justify-content: space-between;"> <div> <p>15683</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>Item #2a, b, c & d in 6a, taken from birth cert.</p> </div> <div> <p>15678</p> <p>CERTIFICATE OF DEATH</p> </div> </div>											
1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Illinois b. COUNTY Cook ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hinsdale IL					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hosp.						d. STREET ADDRESS 821 Phillippa St.				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Baby Charles A. Middaugh						4 DATE OF DEATH Month Nov Day 22 Year 1967					
5 SEX Male		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 11/20/67		9 AGE (in years last birthday) yrs 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Ind				12 CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME James William Russell						14. MOTHER'S MAIDEN NAME PATRICIA R.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO _____		17 INFORMANT Hospital Records				Address	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity, Respiratory distress syndrome DUE TO (b) Premature birth (1900 gm) neonatal death DUE TO (c) Respiratory distress syndrome (clinical) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from 11-20, 1967 to 11-22, 1967 that (I) (we) last saw the deceased alive on 11-22, 1967 , and that death occurred at 4^{PM} M, from causes and on the date stated above											
22a. SIGNATURE Albert J. Modlin						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Albert J. Modlin, M.D.						22d. ADDRESS 704 Gorman Ave., Laurel, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/4/67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23d. LOCATION (City or town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.						25a. REC'D BY REGISTRAR DEC 6 1967		25b. REGISTRAR'S SIGNATURE William J. Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15684

15679

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Virginia b. COUNTY Fairfax ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annandale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS 8142 Briar Creek Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Lewis Mikelson		4. DATE OF DEATH Month Day Year November 9 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 November 1929
9. AGE (in years last birthday) 37 yrs		10. IF UNDER 1 YEAR Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot		10b. KIND OF BUSINESS OR INDUSTRY Commercial Airlines	
11. BIRTHPLACE (County & State, or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gunder Mikelson		14. MOTHER'S MAIDEN NAME Opel Austin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1947		16. SOCIAL SECURITY NO. 521-30-3541	
17. INFORMANT The Medical Records		The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>E coli septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myelogenous Leukemia</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute renal failure			19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 30, 1967</u> , to <u>November 9, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 9, 1967</u> , and that death occurred at <u>5:20M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard A. Creech</u>		22b. DATE SIGNED 10 November 1967	
22c. PHYSICIAN'S NAME (Type) Richard H. Creech, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/13/67	23c. NAME OF CEMETERY OR CREMATORY National Memorial Park	23d. LOCATION (City or Town) (County) (State) Falls Church; Fairfax; Va.
24. FUNERAL DIRECTOR <u>Everly-Wheatley Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 14 1967</u>	
ADDRESS Alexandria, Va.		25b. REGISTRAR'S SIGNATURE <u>William J. Jordan</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15685

15680

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>Mont. Co.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c LENGTH OF STAY IN 1b <u>4 D.O.A.</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>9318-Crawford-Turner</u>	
3 NAME OF DECEASED (Type or print) <u>Richard C. Miller</u>		4 DATE OF DEATH <u>Nov. 7 1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan 5, 1953</u>
9 AGE (In years last birthday) <u>14</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>James Miller</u>		14 MOTHER'S MAIDEN NAME <u>Harriet Lyon</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>father</u>		18 NAME OF INFORMANT <u>James E. Miller</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>due to hanging</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>13 min.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WA. AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18) <u>accidental</u>	
20c TIME OF INJURY Month, Day, Year <u>Nov 7 1967</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f (City or town) (County) (State) <u>Rockville Montgomery Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Noturo causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>11/8/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11-13-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Gettysburg Natl Cem.</u>	23d LOCATION (City or town) (County) (State) <u>Gettysburg, Penna.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>NOV 13 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

15685

CERTIFICATE OF DEATH

15681

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c LENGTH OF STAY IN 1b 81 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Shirley Middle S. Last MILLER		4. DATE OF DEATH Month November Day 24 Year 1967	
5 SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH February 21, 1907
9 AGE (In years last birthday) 60 yrs.		10 UNDER 1 YEAR Months Days	11 UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) United States Navy		10b KIND OF BUSINESS OR INDUSTRY Adm. Ref.	
11. BIRTHPLACE (County & State, or foreign country) Eustis, Florida		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irvin MILLER		14. MOTHER'S MAIDEN NAME Elizabeth LaRUE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1927-1956-57		16. SOCIAL SECURITY NO 1927-1956-57	
17. INFORMANT Wife		Address Box 323 Route 3 Annapolis, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 14 September 1967 , to 24 Nov , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 24 November 1967 , and that death occurred at 755A M. from causes and on the date stated above.			
22a. SIGNATURE R.B. Moquin		22b. DATE SIGNED 24 Nov 67	
22c. PHYSICIAN'S NAME (Type) Cdr R. B. Moquin, USN		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, or other disposal	23b. DATE THEREOF 11/25/67	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREM.	23d. LOCATION (City or Town) (County) (State) PRINCE GEORGE CO. MD
24. FUNERAL DIRECTOR John H. Taylor, Sr.		25a. REC'D BY REGISTRAR NOV 28 1967	
ADDRESS Annapolis, Maryland		25b. REGISTRAR'S SIGNATURE Edisona, T...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/67

items 18, 21 film #395
12-6-67 mt
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15582

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c LENGTH OF STAY IN b		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3 NAME OF DECEASED (Type or print) <u>Victor</u> First <u>C.</u> Middle <u>Miller</u> Last d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hosp.</u>		4 DATE OF DEATH Month <u>11</u> - Day <u>11</u> Year <u>1967</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH
9 AGE (In years lost birthday) <u>58</u> Approx.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red) <u>Carpenter</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>Kirby Lee Miller</u>		14 MOTHER'S M maiden name <u>Nannie E. Clark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No USN World War II</u>		16. SOCIAL SECURITY NO. <u>225-09-8628</u>	
17. INFORMANT <u>Kenneth W. Spencer</u> Address <u>St Leonard Maryland</u>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>Nov. 12, 1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <u> </u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>1311121</u>	23b DATE THEREOF <u>Nov. 13, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>McCormick Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Middleton, Frederick Virginia</u>
24 FUNERAL DIRECTOR <u>David Funeral Home</u> Address <u>Shackley, Virginia</u>		25a REC'D BY REGISTRAR <u> </u> 25b REGISTRAR'S SIGNATURE <u> </u>	
Rep. By <u>J. Arthur Miller</u> Sp. H. <u>Takoma Park Home</u>		DATE <u>NOV 17 1967</u> <u>gchambers judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15683

15683

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a STATE Maryland b COUNTY Montg.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c LENGTH OF STAY IN 1b 15	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4701 Willard Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last LILLIE L. MOLTER		4 DATE OF DEATH Month Day Year 19 11 24	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 10, 1877
9 AGE (In years last birthday) 90 yrs		10 IF UNDER 1 YEAR FINDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY At Home	
11 BIRTHPLACE (State or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Charles E. Lusby		14 MOTHER'S MAIDEN NAME Harriet Fister	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 219-54-9300	
17 INFORMANT Mrs. Mary L. Pumphrey, Dtr., Same as #2		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 436 IMMEDIATE CAUSE (a) Pneumonia Bronchitis DUE TO (b) Arteriosclerosis Coronary DUE TO (c) Heart		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Stroke	
20c TIME OF INJURY Month Day Year Hour a.m. 6:22 1967		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home		20f (City or town) (County) (State) Bethesda, Md.	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN G. BALL		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/21/67	
23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION (City or Town) (County) (State) Suitland, Maryland	
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Washington, D.C.		25a REC'D BY REGISTRAR DATE NOV 24 1967	
25b REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 11/18/67	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
15684			
1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown	
c. LENGTH OF STAY IN 1b 1 hour		d. STREET ADDRESS Rt. #1, Box 183	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Monroe		4. DATE OF DEATH November 11 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-67
9 AGE (In years last birthday) yrs 1		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Olney, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Donald B. Monroe	
14. MOTHER'S MAIDEN NAME Doris Ann MC Bride		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 750 X Anencephalic monster DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 11/11 , 19 67 , to 11/11 , 19 67 , that (1) was lost saw the deceased alive on 11/11 , 19 67 , and that death occurred at 4:00 AM , from causes and on the date stated above			
22a. SIGNATURE James P. Kerr		22b. DATE SIGNED 11/11/67	
22c. PHYSICIAN'S NAME (Type) JAMES P. KERR		22d. ADDRESS Damascus, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 11-12-67	23c. NAME OF CEMETERY OR CREMATORY LAYTONSVILLE	23d. LOCATION (City or Town) (County) (State) LAYTONSVILLE Mont. MD.
24. FUNERAL DIRECTOR Francis J. Barber		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Laytonsville Md		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE NOV 14 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

15690

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15685

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C.		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 4001 Linnian Avenue, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDGAR NMI MORRIS		4. DATE OF DEATH Month Nov. Day 26 Year 1967			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1888	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 Year Months 26 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse		11. BIRTHPLACE (County & State, or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Aaron M. Morris		14. MOTHER'S MAIDEN NAME Inez Mauldin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO.		17. INFORMANT Mary T. Morris, Wife, Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - Myocardial Infarction DUE TO (b) Coronary atherosclerosis Heart Disease DUE TO (c) 2 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from NOV 15, 1965 to NOV 25, 1967 that (I) (we) lost saw the deceased alive on NOV 1, 1967 , and that death occurred at 11:00 M, from causes and on the date stated above.					
22a. SIGNATURE G. Lawn Thompson		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/26/67	
22c. PHYSICIAN'S NAME (Type) G. Lawn Thompson		22d. ADDRESS 4936 Rodman St., NW, Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/67		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
23d. LOCATION (City or Town) Washington, D.C.		(County)		(State)	
24. FUNERAL DIRECTOR Jos. Gawler's Sons, 5130 Wis. Ave, Wash., D.C.		ADDRESS		25a. REC'D BY REGISTRAR DEC 4 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge					

The first part of the report
 describes the general situation
 of the country and the
 progress of the work.
 The second part contains
 a detailed account of the
 results of the investigations
 and the conclusions drawn
 from them. The third part
 gives a list of the names
 of the persons who have
 been engaged in the work
 and the names of the
 institutions to which they
 belong. The fourth part
 contains a list of the
 names of the persons who
 have been engaged in the
 work and the names of the
 institutions to which they
 belong. The fifth part
 contains a list of the
 names of the persons who
 have been engaged in the
 work and the names of the
 institutions to which they
 belong.

15691

CERTIFICATE OF DEATH

15686

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>47-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
c. LENGTH OF STAY IN 1b <u>Year-5 Mos-11 Days</u>		d. STREET ADDRESS <u>616 QUINTANA Pl. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lawrence Benjamin Muzzy</u>		4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 2, 1878</u>
9. AGE (In years lost birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATISTICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT LABOR</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>WASHINGTON DC.</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>DR. ARTHUR MILLS MUZZY</u>		14. MOTHER'S MAIDEN NAME <u>ROSE MAY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-44-7310A</u>	
17. INFORMANT <u>ROBERT L. MUZZY</u>		Address <u>THAMA PARK, 809 FORSTON DR. MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC PNEUMONIA</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>Nov 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 17</u> , 19 <u>67</u> , and that death occurred at <u>9:45</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Boris Rarkin</u>		22b. DATE SIGNED <u>11/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RARKIN</u>		22d. ADDRESS <u>1019 Union Blvd East, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>17 Nov. 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON DC.</u>
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME, INC.</u>		25a. REC'D BY REGISTRAR <u>7400 Greenbelt Ave., N.W., DC 20016</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 17 1967</u>	

